The Old Mutual 2005 Healthcare Survey
towards Social Health Insurance
Restructuring the healthcare system towards a more equitable solution for all South Africans has been the key driver of the dynamic and ever-changing environment faced by all healthcare industry players over the last five years.

A solution for the low income market is still to be found and over the past two years some of the many issues the industry has had to face include the practicalities of implementing a newly defined set of Prescribed Minimum Benefits, the introduction of Designated Service Providers, the likelihood of the implementation of a Risk Equalisation Fund, the challenges of dealing with HIV/AIDS and single exit pricing for medicines.

In this, our 7th survey on healthcare since 1994, we continue to monitor and to report on employer perceptions of the healthcare industry and medical scheme issues.

We measure the impact of new issues that the industry has had to deal with over the past two years as well as challenges currently faced by employers. We also elaborate on trends that have emerged over the past decade. In addition we identify new focus areas and trends that are likely to be significant for employers and other stakeholders in the future.

The 2005 survey results and accompanying analysis can be used to assist in preparing employers for future changes on the road to a social health insurance system. It is also useful for anyone who has an interest in healthcare funding in South Africa.
Background

Profile of Participants

To ensure that the 2005 Healthcare Survey was representative and that the results would be meaningful across a broad range of companies, a stratified random sample of employers in the private, parastatal and public sectors was targeted. The following criteria were part of the sampling methodology: size of workforce, type of medical scheme (open versus restricted/closed membership), industry sector, as well as geographic location. As with previous surveys, the primary focus remains the larger employer groups with more than 200 employees. However, as with the 2003 survey, a sample of small-medium enterprises or SME’s (50 - 200 employees) has also been included.

A total of 100 face-to-face interviews were conducted using a structured questionnaire. The interview was conducted with a senior person from human resources or finance and the questionnaire was completed during the interview. This year a total of approximately 1,5 million medical scheme lives are represented in this survey, depending on the extent to which dependants are covered. The 2003 survey represented some 700,000 lives, or beneficiaries.

37 of the 100 employers interviewed offer their staff medical scheme membership of a closed scheme, representing some 413,000 employees who have cover. The balance of 63 employers offer membership in an open scheme environment, representing some 183,000 employees enjoying cover. This amounts to a total of some 600,000 members covered either by closed or open medical schemes. The 2003 survey represented some 280,000 members.

In order to compare the open versus closed scheme statistics with previous surveys, it should be remembered that 2003 was the first year that included SME’s in the sample (26 of the 100). In 2005 we have 21 SME’s out of the 100 companies surveyed. Due to their small size SME’s always offer only open scheme membership, so both 2003 and 2005 overall results will show a heavier weighting towards open schemes. The increase in closed scheme representation to 37% of total schemes in 2005, versus 26% of total schemes in 2003, is a consequence of a greater percentage of larger employers in the sample.

It is interesting to note that of the 100 employers interviewed in 2005, there has been no movement from the closed to open scheme environment and also no movement in the other direction within the last two years. However, of this same sample of employers, eight have moved from a closed to an open scheme environment in previous years since 1997 and there is one employer who switched from an open to closed scheme in the same period.
Key Findings

Healthcare Strategy
69% of employers have a documented healthcare strategy in place for their company in 2005, compared with 20% of employers in 2001 and 2003.

Affordability of Healthcare
Since the first survey in 1994, the control of healthcare costs has been rated as the top strategic issue by all seven groups of employers. Bringing all employees onto a health plan has moved into second place in 2005 and is closely linked to the current focus on Social Health Insurance and the need for greater coverage of low income employees.

Transformation and Social Health Insurance
All 100 employers surveyed say they want to play a part in the process of transformation and in the decisions taken that affect both employer and employees. This finding contrasts sharply with the 62% of respondents who say they do not understand the impact of SHI on the healthcare industry. There is significant opportunity for engagement so that employers understand the objectives of SHI.

The analysis of the opinions of employers regarding the proposed Health Charter indicates that they believe the most important element is the necessity for greater collaboration between the private sector and government for the good of the South African healthcare industry. Employers are sceptical about the success of the practical implementation of transformation and would like more information on the roll-out of SHI and other initiatives aimed at transforming the healthcare industry.

82% of respondents believe that employers should subsidise employee healthcare costs in the new SHI environment but they are not willing to pay more than the total amount that they currently set aside in total subsidies for employee healthcare.

Low income market and Prescribed Minimum Benefits
Only 28% of employers rate the current set of Prescribed Minimum Benefits as affordable for the lower income market.

HIV/AIDS
Over the past five years employers have made major strides in putting measures in place to manage HIV/AIDS in the workplace. In 2005 71% of employers surveyed have already documented their HIV/AIDS strategy with a further 8% saying they will do so within the next twelve months. 79% of employers either have an HIV/AIDS workplace policy in place or are about to do this. The five different groups of employers surveyed since 1997 have identified the impact of HIV/AIDS on healthcare funding as one of the top three strategic issues facing them every year since 1997 (third in 2005) and it is pleasing to note that they have dealt effectively with this issue. They have taken the lead on managing the pandemic in an environment that has been largely devoid of HIV/AIDS strategy. They appear now to be “marking time” with regard to further actions.

Member Education
For the first time member education is rated amongst the top five key strategic issues for employers. The complexity of the medical scheme environment and the many changes constantly facing the South African healthcare industry mean that employers have recognized the critical importance of the need for ongoing information and communication. It is also an area where much guidance is sought by employers, including professional advice from consultants, brokers and others.

Risk Equalisation Fund
The Risk Equalisation Fund (REF) raises a number of issues for employers and it is clear that there is a lack of understanding as to how the REF will help to equalise contributions across the industry. The overriding concern voiced by respondents is the belief that schemes will decrease their risk management interventions as they perceive that there is less incentive to manage risk. Another concern is that there is nothing in place to limit chronic medicine utilisation. Employers also believe that the REF will impact negatively on the wealth and morale of schemes that manage risk well. Although there appears to be some support in principle for the objectives of the REF, there is much uncertainty regarding the source of the extra income needed by schemes that must pay in.

Post Retirement Healthcare
42% of employers surveyed provide no post-retirement healthcare funding whatsoever. Unless the cost of healthcare inside medical schemes can become more affordable it is unlikely that the average pensioner will be able to self-fund the full contribution, either in open schemes, or inside closed schemes. This is a different type of low income consumer, besides the low income employee for whom medical scheme membership is unaffordable, who inevitably also becomes a burden on the State.

GEMS
Open scheme and SME employers believe that the Government Employees Medical Scheme will cause contributions to increase for those schemes affected by the withdrawal of government employees.
The control of healthcare costs remains the most significant strategic issue facing employers in 2005. This perception has remained unchanged amongst the 7 different groups of employers surveyed since 1994. It is however noticeable that fewer employers have selected cost control as a top issue, a trend which commenced in 2003 (39% of employers versus 52% of employers in 2001). We believe this might be due in part to the fact that the industry experienced lower member contribution increases during the past two years than previously.

Three of the other four issues appearing in the top five were all rated as top strategic issues in 2003 and we note that bringing all employees onto a health plan has moved up to second place from fifth place. This is not surprising considering the current focus on Social Health Insurance and the coverage of low income employees in the industry. Member education has emerged as a key strategic issue for the first time in 2005, in fourth place when the rating of 10 is used and in second place when both ratings 9 and 10 are used. The shift in importance of member education could be due to the fact that employers believe that educated members will aid in managing the cost of healthcare. Pensioner pre-funding remains in sixth place where it moved in 2003 (third place in 2001), the decrease in strategic importance being due to the fact that many employers have dealt with this issue. The Risk Equalisation Fund emerges in seventh place.
Employers commented on all the strategic issues that they rated 7 or above. The main points made about the top issues are as follows:

**Cost control**

The common theme here is that employers believe that they are unable to do anything about ever-increasing healthcare costs and that they do not know how much longer employers and employees can continue paying escalating contributions well above inflation rate. Tools that they use to manage costs are managed care, benefit design, restructuring of benefits and member education. High investment returns also play a role. Employers say they believe that cost control is easier inside a closed scheme.

**Bringing all employees onto a health plan**

Although 22 employers said that they had already done this, this is definitely still an issue for many: for some there is a willingness to contribute as much as 15% of salary or R250 per month for this purpose and for others it is clear that a blanket contribution is unaffordable to the company. “If I have to contribute 10% for all employees I will be bankrupt”. The possibility of changing the employer subsidy policy for future employees, in order to cover more of the workforce, may be an option for these employers.

Some employers comment that they have primary healthcare facilities on site and their biggest need is hospital cover for these employees. They are also concerned about the cost of chronic medication.

**Impact of HIV/AIDS**

This strategic issue was widely commented on by employers, reflecting their willingness to invest in the wellbeing of employees who are HIV positive. The desire to have a productive and happy workforce is mentioned repeatedly in various sections of this survey and also linked to the wider economy: HIV/AIDS is viewed as a pandemic that needs to be tackled on all fronts, but employers are very worried about the ongoing costs as well as the ultimate costs associated with the pandemic. Higher infection rates and loss of productivity are issues that employers say they are grappling with. The actions that employers are taking are covered in detail in the HIV/AIDS section of this report and show how extensively employers have tackled the consequences of dealing with HIV/AIDS in the workplace over the past five years.

**Member Education**

For the first time member education is rated amongst the top five strategic issues. In the ever-changing and complex medical scheme environment, together with the uncertainties facing consumers and other stakeholders, the need for information and communication is key. New regulations such as the expansion of Prescribed Minimum Benefits with the inclusion of the Chronic Disease List in 2004 and anti-retroviral treatment in 2005, the introduction of Designated Service Providers, the licensing of dispensing doctors, the introduction of single exit medicine pricing, etc. all demand detailed explanation to ensure that members are informed and understand what to do.

It is likely that as a consequence of all of the above taking place within the last two years, employers have identified member education as an important strategic issue for the first time in 2005. The Council for Medical Schemes has also emphasized the need for greater member education and in 2004 published a Fair Treatment project document which is to be used as a blueprint for actions in relation to the promotion of fair treatment in the short, medium and longer terms. The Council’s vision is a medical scheme industry which is regulated to protect the interests of members (and beneficiaries) and to promote fair and equitable access to private health financing. Trustees of medical schemes and employers have a large part to play in ensuring that the interests of members and their dependants are protected, and member education plays a big role.

Comments from employers also tell us that they find it extremely difficult to be successful educating members as employees prefer personal explanation. They say that employees or members need to be given the same message repeatedly and therefore member education is an ongoing priority for them. Many employers say they do an enormous amount of communication e.g. they have peer educators who move around in offices, they conduct road shows and some employers communicate healthcare information in all languages and at all levels.

The complexity of the medical scheme environment is unlikely to decrease in the near future, although the long term vision for Social Health Insurance does aim to simplify choices for members of medical schemes. However, until this vision is fully realised, members will have to contend with many more issues that are difficult to understand. One area that is likely to need greater member education is that of preferred provider networks, including profiling of GP’s, specialists, hospitals, etc. that will help members to choose cost-effective providers and ultimately keep medical scheme contributions down.

**Providing affordable healthcare**

This is closely related to the top two strategic issues identified by employers and has many of the same key concerns. It continues...
to be a particularly relevant issue to employers due to the cost-shifting that has taken place from employer to employee over the last decade. This has meant that much of the burden of rising healthcare costs is borne by the employee, resulting in increasingly unaffordable member contributions for certain sectors of the workforce.

The impact of escalating healthcare costs and changing employer subsidy policies on an individual employee’s medical scheme contribution as a percentage of his or her income was highlighted in the 2001 survey by means of a case study. This predicted the serious affordability problems large numbers of employees would experience if rising healthcare costs were not effectively contained. The great extent of shifting of healthcare costs that had taken place from employer to employee was extensively highlighted in the 2003 survey. What many employers are experiencing now is that even though they provide a subsidy to all employees, many individuals are not able to make use of this because it is too small in relation to the total contribution. Thus the need to cap the employer subsidy has resulted in a significant percentage of the workforce buying down into cheaper options, deregistering some of their dependants or being unable to continue to afford medical scheme cover. This becomes a new issue for employers as productivity is impacted by the fact that employees need to use public healthcare facilities and absenteeism increases.

### Other Key Issues

In 2003 pensioner pre-funding as a key strategic issue moved from third to sixth place and it remains in sixth place in 2005. As reported in 2003 employers no longer rate this as a critical issue as they have largely dealt with pensioner funding. The healthcare retirement section of this report reveals that 42% of employers surveyed in 2005 do not fund pensioners. The Risk Equalisation Fund also features as a strategic issue but the scale of importance places it well below the other issues.

### Employer Health Strategy

Employers were asked whether their company had a written health strategy/policy with measurable goals and objectives. Compared with 2001 and 2003 where only 1 in 5 employers had a written healthcare policy, now nearly 70% have a documented strategy:

![Written healthcare strategy chart]

The 69% of respondents who already have a documented health strategy in place are broken down further as follows:

- 34 out of the 37 closed scheme employers have a strategy in place
- 64 out of the 79 larger employers (excluding the 21 SME’s) have a strategy in place
Drivers of overall healthcare costs

Employers were asked to rate their perception of the level of impact of a predetermined set of key drivers of healthcare costs. The table below sets out the cost drivers perceived to have the most cost impact:

<table>
<thead>
<tr>
<th>Cost Driver</th>
<th>Greatest Impact</th>
<th>Significant Impact</th>
<th>Noticeable Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact of HIV</td>
<td>26</td>
<td>21</td>
<td>1</td>
</tr>
<tr>
<td>Increasing provider costs</td>
<td>21</td>
<td>21</td>
<td>13</td>
</tr>
<tr>
<td>Pensioner impact</td>
<td>21</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>New drugs/medicines</td>
<td>18</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Fraud and overservicing</td>
<td>15</td>
<td>26</td>
<td>4</td>
</tr>
<tr>
<td>Medical advances/new procedures</td>
<td>13</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>Cost of PMB</td>
<td>13</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>Member demand</td>
<td>6</td>
<td>21</td>
<td>9</td>
</tr>
</tbody>
</table>

There were four additional categories amongst the predetermined set which were rated significantly less than any of the above cost drivers. These were healthcare administration costs, ineffective benefit design, ineffective cost control tools, with influx of new members having received the lowest rating.

As seen in the above table the impact of the cost of HIV has come through as the driver with the biggest impact whereas in previous surveys it was seen as a strategic issue but not necessarily as a big cost driver.

The two drivers with the second biggest impact are increasing provider costs and the impact of pensioners, with equal weighting. The area of ever-increasing costs in the delivery of care was the top driver in 2001, but fell to second place behind fraud and over-servicing in 2003. It emerges once again in second place, this time behind the cost of HIV/AIDS. However, overall the increasing provider costs in the delivery of healthcare emerges as the number one cost driver when all three levels of impact shown in the graph are taken into account. Note that the cost of new drugs/medicines as well as medical advances/procedures also relate to the cost of the delivery of care and have been separated for the first time in 2005. Both emerge with high ratings.

Note that the impact of pensioners was previously labelled “ageing population’ and this renaming has probably led to the higher rating as a driver of costs than in previous surveys. This could also be as a result of the greater awareness of the cost of pensioners relative to the younger age groups following the Prescribed Minimum Benefits and Risk Equalisation Fund impact studies that have been made available to the industry.

While fraud and over-servicing has fallen to fifth place as biggest cost driver, it is the driver rated most highly as ‘significant’ by employers in 2005. It was possibly rated as the driver with the biggest impact in 2003 due to the awareness created by the newly established industry forensic unit at that time.

It is interesting to note that in 2001, regulatory intervention was rated as the sixth largest cost driver, in 2003 it was seen as the third key cost driver and in 2005 the cost of Prescribed Minimum Benefits is seen overall as one of the top four drivers of costs equivalent to the impact of fraud and over-servicing when all three levels of impact are considered.
The method of employer healthcare funding and the extent of the employer healthcare subsidy are key components of employer remuneration policy. In 2003 21% of the respondents surveyed had moved to a total cost to company basis of funding i.e. they had capped their healthcare costs by shifting the total employer subsidy to the cash package of the employee. In 2001 only 8% of employers had chosen this method of funding and it appeared likely that the increase to 21% in 2003 might become a future trend as several employers in the 2003 survey indicated their intention to explore this method of distancing themselves from employee healthcare costs.

In the 2005 sample of employers only 2 respondents reported that the total employer subsidy is included in the cash package of employees, with a further 3 respondents telling us that they offer the total cost to company basis (or the cash package basis) to a section of the workforce while the rest receive an employer subsidy towards their medical scheme contribution. In the light of this finding the detail of the balance of the various employer subsidy policies has been included in this report.

**Employer Medical Scheme Subsidy Policy**

A summary of the way in which employers currently subsidise the cost of medical scheme benefits for their employees can be seen in the graph below:

The detail of the company subsidy has been explored in depth for the 94 employers not using the cash package basis of funding (one response was excluded) and illustrates the wide variation in subsidy policy:
Employer Healthcare Financing & Subsidy Policy continued

65 employers pay a percentage of contributions with no limit
- 50% of total contribution (44 respondents)
- 60% subsidy (11 respondents)
- 75% subsidy (2 respondents)
- 80% subsidy, no limit, members & dependants (2 respondents)
- 50% subsidy, no limit, members & dependants
- 50% contribution & R49
- 50% subsidy, managers 100%
- 75% subsidy - merger, cost to company being phased out
- 80% subsidy, no limit, members & dependants - merger, some of previous employees on cost to company. Not renewed as new employees join
- % subsidy, no limit, members & dependants

15 employers pay a subsidy based on income
- Salary-based sliding scale, larger amount for lower income (6 respondents)
- 80% subsidy, no limit, salary-based sliding scale, members & dependents (4 respondents)
- % of total contribution for member + dependants, salary-based sliding scale (3 respondents)
- Across salary categories a 2/3 contribution. Benchmark as follows: Member R727, M+1 R1233, M+2 R1459, M+3 1682, M+4 R1905
- Subsidy on sliding scale by salary category

12 employers pay a percentage of contributions with a ceiling limit
- 60% capped at R1853 all salary groups
- 50% limit R1383
- 50% of total contribution (member + dependants) - with limit based on sliding salary scale
- 60% of total contribution (member + dependants) - with limit R1850
- 60% of total contribution (member + dependants) - with limit R1800
- 60% of total contribution (member + dependants) - with limit R1500
- % subsidy with limit R1400, members & dependants

2 employers pay set monetary amounts
- Set amount R1200
- Set amount R750
Rand Value of current average monthly subsidy per employee

For the first time in 2003 employers quantified the average value of subsidy per employee. The average amount calculated for all employers was R883 per month, but a very wide variation was observed. In 2005 the average employer subsidy is in excess of R1000 per employee, based on the information above and data collected on scheme benefit structures. However this once again varies widely depending on the subsidy policy and the option chosen by employees.

The majority (more than 70% compared with 68% in 2001 and 2003) of employers are still providing a subsidy for the member and his/her immediate family.

Employer subsidy policy and SHI

Respondents were asked whether they believe that employers should subsidise employee healthcare costs in the new Social Health Insurance model:

In the new SHI model should the employer subsidise employee healthcare costs?

- **Yes**: 82%
- **No**: 12%
- **Don’t know/Not sure**: 6%

The reasons for and comments on the affirmative responses are:

- Already contribute towards medical aid (52 respondents)
- Employees can’t afford it on their own (3 respondents)
- No more than they currently pay, it could cripple smaller companies if they have to pay more (2 respondents)
- Want to continue with cost to company basis (1 respondent)
- Seen as part of social responsibility (1 respondent)
- “It’s in our interest to have productive employees” (1 respondent)
- Not sure if they can afford it (1 respondent)
Employer Healthcare Financing & Subsidy Policy continued

The analysis of the negative responses shows us that these employers believed that an SHI contribution would be in addition to their current medical scheme employer subsidy. They indicated “no” because they are not prepared to pay any additional amount.

It is important for employers to know that any SHI contribution would not operate in isolation as an additional contribution over and above medical scheme contributions. If it is implemented it is envisaged that direct contributions to medical schemes would be reduced by a universal subsidy and the amounts collected from the SHI contribution. Any SHI contribution is likely to be income-based and as a result lower income earners stand to benefit substantially. As discussed in the Transformation section of this report there are alternative tax reform proposals.

Employer subsidy policy in the future

Respondents were asked how they believe employers should fund employee healthcare in the future:

The four employers who suggested that the amount be mandated by government indicated that they would not be prepared to pay more than they currently contribute. It is notable that the issue of employers paying no more than they currently pay recurs in several areas of this survey. The impact of healthcare costs on Company bottom-line that was highlighted in the 2003 survey remains a key issue.

Employers were asked what incentive government could offer them to encourage them to continue to make or to consider making a contribution towards every employee’s healthcare:

- Offer company tax benefit (25 respondents)
- Don’t know (24 respondents)
- Incentives for healthcare programmes that the company implements for good of staff (6 respondents)
Taxation of medical scheme contributions

In the Minister of Finance’s 2005 budget speech it was proposed that for the 2006 tax year the current tax benefit on medical scheme contributions would be capped at an amount still to be determined. Employers were asked how this would affect their company’s current policy towards funding contributions:

Although 82% of respondents say that they would not alter their subsidy policy, any cap on the amount that receives preferential tax treatment will mean that some employees will receive less effective post-tax subsidy towards their medical scheme contribution, especially the higher earners who have elected more expensive benefit options.

“The issue of employers paying no more than they currently pay recurs in several areas of the survey...”
Response to HIV/AIDS

Since the first survey in 1994 we have seen a dramatic shift in the way in which employers have risen to the challenge of dealing with the HIV/AIDS pandemic. One of the ways in which employers have transformed the HIV/AIDS landscape is in their approach to dealing with HIV positive employees. We have observed how employers have moved from having no measures in place, to introducing HIV/AIDS management programmes, paying for anti-retroviral treatment for their employees (in 2003 it was significant that employers spent more per employee and per beneficiary on HIV/AIDS medication than they did on other chronic diseases), to implementing regular HIV/AIDS prevalence testing and monitoring in the workplace. Now we see that 71% of employers surveyed already have a documented HIV/AIDS strategy in place:

It is notable that 36 out of the 37 closed scheme employers either already have a documented HIV/AIDS strategy or are busy putting one in place.

25 of the respondents who indicated that their company has a documented HIV/AIDS strategy, also reported that the company has undertaken prevalence testing to establish what percentage of their workforce is HIV positive.
The graph below shows the variation in workforce HIV/AIDS status amongst the 12 employers who were prepared to share their results of the prevalence testing in the survey. The balance of 13 employers indicated that the information was confidential and therefore did not want to disclose the percentage.

It is meaningful to compare the results above with those of 2003 where there were 16 employers prepared to share their workforce HIV/AIDS status, and an average of 15% of the workforce was HIV positive. The 2005 measures reveal a weighted average of 19.4% of the above workforce that are HIV positive, for the 12 employers that were prepared to disclose their figures. There are 57 800 HIV positive employees amongst a total workforce of 297 626 represented by the 12 employers.

It is interesting to note that of the 25 employers who have conducted HIV/AIDS prevalence testing, 16 believe that the employer should be responsible for providing cover, and of these 16 employers, only 9 believe that this should be done via the medical scheme, even though this is currently the more tax effective route. The other methods are discussed later.

The fact that we are seeing very high prevalence rates amongst workforce where HIV/AIDS testing has been conducted is of great concern, even if to some extent the above sample of employers might possibly yield a higher than average result, if they believe that their HIV/AIDS prevalence may be higher than average and therefore consider testing necessary. Employers mention the very low penetration of workforce coming forward for HIV/AIDS treatment and their concern that HIV/AIDS management programs are not yielding the results intended. Despite employers having taken the lead in managing HIV/AIDS their actions are hampered by the stigma widely associated with the disease.

“Over the past five years employers have made major strides in putting measures in place to manage HIV/AIDS in the workplace…”
Response to HIV/AIDS continued

Only 27% of employers (compared with 49% in 2003) believe that the employer should be responsible for the cost of providing anti-retroviral treatment for HIV/AIDS:

The reasons given for employer attitudes towards the funding of anti-retrovirals are as follows:

Of the 27 respondents who believe that the employer should fund the costs we see that their biggest reason for doing so is that it is their contribution towards social responsibility. They also say that it is in their interest to keep their employees productive for longer.

Of the 60 respondents who believe that the employer should not pay for anti-retrovirals, 20 indicated that the reason for saying so is that it is currently paid for by the medical scheme, and a further 14 have indicated that it is too big a financial burden. It is notable that all SME’s say they believe that they should not fund anti-retroviral treatment (ART), which is probably related to the cost impact on a smaller company or to the fact that SME’s sit inside open schemes and ART is already part of PMB’s. In the 2003 survey we saw the heavy focus on Company bottom-line and this theme remains in 2005.

The employer responses regarding whether the medical scheme should be used as a vehicle for HIV/AIDS funding showed:

- 12 respondents believe the medical scheme should be the sole vehicle for funding HIV/AIDS
- 7 respondents believe that the scheme should fund HIV/AIDS together with Government
- 17 respondents believe that the scheme should fund HIV/AIDS together with the employer
It is interesting to see how employer beliefs differ from reality, since cover for anti-retroviral treatment for HIV/AIDS was introduced during January 2005. The survey interviews were conducted in April/May 2005, when schemes were already paying for anti-retroviral treatment. The 9% in the category labelled ‘Depends’ indicated that they believe it should depend on the government roll-out of anti-retrovirals and the impact on medical scheme contribution rates.

As in past surveys we have measured the actions that employers have taken in their response to HIV/AIDS, as well as actions that they intend to take within the next 12 months:

When asked if treatment for HIV/AIDS should be part of the Prescribed Minimum Benefits, employers responded as follows:

Do you believe HIV/AIDS should be part of PMB's?

<table>
<thead>
<tr>
<th></th>
<th>% of Employers</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>33</td>
</tr>
<tr>
<td>No</td>
<td>51</td>
</tr>
<tr>
<td>DK/Not sure</td>
<td>7</td>
</tr>
<tr>
<td>Depends</td>
<td>9</td>
</tr>
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</table>

Actions taken / to be taken to manage impact of HIV/AIDS

<table>
<thead>
<tr>
<th>Action</th>
<th>Actions taken</th>
<th>Actions to be taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS strategy development</td>
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<td>8</td>
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<tr>
<td>HIV/AIDS workplace policy</td>
<td>69</td>
<td>10</td>
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<tr>
<td>Education and awareness programme</td>
<td>37</td>
<td>11</td>
</tr>
<tr>
<td>HIV/AIDS prevalence survey</td>
<td>25</td>
<td>9</td>
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<tr>
<td>Prevention programmes</td>
<td>23</td>
<td>10</td>
</tr>
<tr>
<td>Actuarial impact assessment</td>
<td>21</td>
<td>12</td>
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<tr>
<td>Access to HIV/AIDS disease management programme</td>
<td>18</td>
<td>15</td>
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<tr>
<td>Voluntary counselling and testing</td>
<td>16</td>
<td>10</td>
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<tr>
<td>Conducted impact analysis to develop a model as a management tool</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>Undertaken estimated cost impact based on the impact analysis</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>Medicine benefit to cover cost of treatment</td>
<td>13</td>
<td>18</td>
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<tr>
<td>Benefit design changed to restrict anti-retroviral treatment</td>
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<td>8</td>
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<tr>
<td>KAP* study</td>
<td>9</td>
<td>16</td>
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<tr>
<td>No action</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Reinsurance of the HIV/AIDS risk</td>
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</table>

KAP* Knowledge Attitudes and Perceptions
The first three actions taken to manage HIV/AIDS are the same as in 2003, where 68% of employers had an HIV/AIDS strategy in place, 56% of employers had implemented education and awareness programmes, and 46% of employers had an HIV/AIDS workplace policy in place. HIV/AIDS strategy and policy development is now the key focus for nearly 80% of employers. This contrasts with the years prior to 2000 where the focus was largely on education and awareness. Education and awareness programmes seem to have reduced in number compared with previous years and the figures in the graph above may suggest that these are now included in workplace policies.

Respondents who offer education and awareness programmes were asked to comment on their effectiveness and we identified four key findings in the verbatim responses:

- The biggest benefit and the greatest need is in the area of counselling
- Employers have great difficulty in measuring the success of these programmes
- The stigma associated with being HIV positive is seen as a significant stumbling block
- Employers believe that Employee Assistance Programme (EAP) actions have increased productivity

Respondents offering disease management programmes to their workforce are experiencing that these benefits are under-utilised and that they have not had the impact that they potentially could have. Employers are telling us that they have not seen much increase in the numbers of employees joining HIV/AIDS disease management programmes. Only four employers supplied information with regard the number of employees registered. It is interesting to see that 8 employers intend to change benefit design to restrict anti-retroviral benefits in the future: this clearly indicates their lack of understanding of Prescribed Minimum Benefits, which from January 2005 included anti-retroviral treatment. Schemes can no longer omit this from benefit design.

For employees that are not members of medical schemes the actions that employers have taken with regard to the treatment of HIV/AIDS are as follows:

<table>
<thead>
<tr>
<th>Action taken by employers for employees not on medical schemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing yet</td>
</tr>
<tr>
<td>Employee Assistance Programme</td>
</tr>
<tr>
<td>Offering anti-retrovirals at no cost to employee</td>
</tr>
<tr>
<td>On-site clinics</td>
</tr>
<tr>
<td>Occupational health monitoring and educating</td>
</tr>
<tr>
<td>HIV/AIDS peer educator programme</td>
</tr>
<tr>
<td>Public Hospitals/Clinics</td>
</tr>
<tr>
<td>Pay for doctors visits</td>
</tr>
</tbody>
</table>

Employers are generally reporting less activity in the area of HIV/AIDS management than they did in 2003, other than in the area of documenting an HIV/AIDS strategy and implementing a workplace policy. It may be that the inclusion of HIV/AIDS treatment in Prescribed Minimum Benefits for employees who are members of medical schemes, has meant that employers feel that the disease is better managed than in the past. Employers are “marking time” while they wait for more employees to come forward to allow the virus to be managed, which shows a reactive rather than a proactive approach.
Employer perceptions of the impact of the regulatory environment in the healthcare industry have been measured across various areas of significance for medical schemes e.g. Medical Schemes Act, Prescribed Minimum Benefits, Chronic Medicine Benefits. The Risk Equalisation Fund, the Health Charter and Social Health Insurance are covered in the section dealing with the Transformation of Healthcare.

When employers were asked for their overall perception of the extent of regulation in the private healthcare industry, 57% were of the opinion that the industry is over-regulated, compared with 39% of employers who thought this way in 2003. Of the 7 employers who consider the industry under-regulated in 2005, the majority commented that the hospital industry needs more regulation. The employers reflected in the ‘other’ category in the graph below were all of the view that the industry is over-regulated in some areas e.g. medicines, and under-regulated in others e.g. hospitals. “Regulation is totally unbalanced: too much where it is least needed and too little where it is most needed” says one large employer.

In 2005, 57% of employers surveyed believe the industry is over-regulated. Reasons given by employers stating why they believe the industry is over-regulated include:

- the regulation of medicine pricing and the impact on pharmacists that remains unresolved
- the licensing of dispensing doctors and the impact on people in the rural areas
- the cost of the implementation of the extended Prescribed Minimum Benefits.
Respondents were asked to comment on the movement in specific areas or issues that the current Medical Schemes Act and Regulations may have influenced. The following table indicates their impressions:

<table>
<thead>
<tr>
<th>Impact of Medical Schemes Act and Regulations on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of Contributions</td>
</tr>
<tr>
<td>Medical Scheme Benefits</td>
</tr>
<tr>
<td>Cost of Subsidies</td>
</tr>
<tr>
<td>Number of members 2003</td>
</tr>
<tr>
<td>Number of members 2005</td>
</tr>
<tr>
<td>Members changing options</td>
</tr>
</tbody>
</table>

It is important to remember that these are employer perceptions, not necessarily reality:

As can be seen in the graph above employers believe that the Medical Schemes Act and Regulations have increased the cost of contributions as well as the cost of employer subsidies. This would largely be due to the fact that 65% of employer subsidies in this survey are a fixed percentage of total contributions without any limit. The reason that employers perceive medical scheme benefits to have increased is probably as a result of the introduction of the 25 chronic diseases that were added to the Prescribed Minimum Benefits in 2004. This change to the Prescribed Minimum Benefit legislation would also lead to option changes as members with one or more of the 25 chronic conditions no longer need to belong to a more expensive option. Also noticeable is the fact that 86% of employers in 2005 state that they believe the number of members has remained unchanged compared with 69% in 2003, suggesting more awareness of the general trend in the industry.

The buy-down of chronic disease sufferers into more affordable options has cost the private healthcare industry a significant amount in lost contributions. These members do not reduce their expectation of benefits; they only reduce their contribution. They keep their inherent burden of disease and risk. The theory is that the load is spread across a wider membership. However, the affordability of that option is heavily impacted by the number of people who require chronic medication and thus the cost for all members is increased when chronic disease sufferers move to a less expensive option. For the industry as a whole this makes it very difficult to offer affordable healthcare.

**Prescribed Minimum Benefits**

Employers were surveyed regarding their understanding of Prescribed Minimum Benefits (PMB). The following summarizes the responses:

- Legislated or minimum level of benefits that a scheme must supply (61 employers)
- New regulations on cover for medical schemes (11 employers)
- Limits from Council for Medical Schemes on what has to be covered (6 employers)
- Minimum benefits for all chronic illnesses (1 employer)
- Don’t know (21 employers)
All 21 employers who do not know the meaning of Prescribed Minimum Benefits are in the open schemes market with 14 of them in the SME sector.

We also tested the employer understanding of the term chronic medication benefits. From the verbatim responses received it is clear that more than 75 respondents understand the term. There were 8 respondents that did not know the meaning and a further 15 respondents that stated they were unsure about benefits.

In the graph below the one employer who understands PMB to be minimum benefits for chronic illness, is included in the 79 employers that understand PMB. Prescribed Minimum Benefits also cover the 270 diagnostic treatment pairs (DTP’s) or treatment for hospital-type conditions.

When asked whether employers believe that members without a PMB chronic condition are receiving a fair deal, the following responses were received:

- 49 employers said yes (all 49 know the meaning of PMB and chronic)
- 31 employers said no (23 of them know the meaning of both)
- 20 employers were unsure

The analysis of the verbatim reasons for responding “yes” show that the 49 employers largely support the principle of cross-subsidisation. The analysis of the reasons for responding “no” reveal that employers believe that there is no incentive to stay healthy and that there is nothing in place to limit chronic medicine utilisation. 5 of the respondents said that the healthy were being penalised.

The attitude towards the principle of cross-subsidisation in general was also tested and the responses received reflect similar sentiments to those described in the preceding paragraph with a particular need expressed for some form of incentive to be healthy.
The structure for Prescribed Minimum Benefits within the medical scheme was also tested. The pie chart below shows that 10% of employers know that they have a separate benefit pool for PMB.

The 44 respondents who indicated that they do not know if they have a separate pool for PMB are all in the SME and open scheme market.

Employers were asked whether in their opinion medical scheme members understand Prescribed Minimum Benefits:

The aspects that they believe make it confusing for members are:

- Certain sectors do not fully understand their rights (23 respondents)
- Too little educational material to explain it or members do not read communication (7 respondents)
- Member apathy until they become ill (2 respondents)
Transformation of the Healthcare Industry

Since the first survey in 1994 the South African healthcare system has undergone substantial transformation. Medical schemes are heavily affected, as they begin to undergo the changes needed to make them a mandatory part of the Social Health Insurance vision that is government’s objective.

Employers are a key player in ensuring that employees understand the impact of the transformation on medical schemes, whether their participation is in the closed or open schemes environment. They have already had to deal with many regulatory changes, the most recent of which are covered in the section on the Regulatory Environment. There are more changes in the pipeline: in January 2004 the Minister of Health stated that the implementation of Social Health Insurance needed to address three main issues. These are risk-related cross-subsidies, income-related cross-subsidies and mandatory cover. The first is being dealt with through the implementation of a Risk Equalisation Fund (REF) and employer perceptions of the REF are explored in depth in this survey. Other transformation issues that employers are dealing with have also been surveyed.

It is important to note that the questions posed to employers were open-ended and that respondents were not led by any prior categorisation of possible answers. This method was used throughout the Transformation section of this report except where responses in the affirmative or negative were being surveyed.

Health Charter

The Health Charter process presents an opportunity to define a role for the Private Healthcare System within Government’s ultimate vision of a National Health System. It should be noted that the interviews with respondents were conducted prior to the Draft Charter being published.

Employers were asked to give their opinion of how the Health Charter is likely to assist the changes taking place in the healthcare industry. 24 respondents said that they did not know sufficient about the Health Charter and so did not comment. The verbatim responses of the balance of the employers were analysed and the following summarizes the most important positive aspects mentioned:

Positive aspects:

- Greater understanding and better relationship between the role players (17 respondents)
- Establishment of more PPP initiatives to improve quality of healthcare (15 respondents)
- Pooling of private and public healthcare resources for the good of all (10 respondents)
- Wealth of knowledge and expertise in Private Healthcare can benefit public healthcare (9 respondents)
- ‘If there are no hidden agendas then it can work’ (5 respondents)
- Any charter is only as good as the implementation plan (3 respondents)
- All role-players must contribute, especially employers (1 respondent)
- Private specialists to render public service at reduced cost, worked well in past (1 respondent)
- Folateng (the private wing at Johannesburg General State hospital) is an excellent example of a private / public partnership that works extremely well (1 respondent)
**Transformation continued**

**Negative aspects:**

- Consultative process seen as window dressing, government not likely to be influenced by other stakeholders (10 respondents)
- If they are not able to get it together, the two healthcare industries (private and public) will polarize even further (5 respondents)
- Roll-out of implementation doubtful (3 respondents)
- Concerned about difficulty of implementation of new healthcare system in rural areas (1 respondent)
- Will not work if service providers are not more flexible (1 respondent)

Employers were also asked what in their opinion, is the most important aspect to “get right” in order for the Health Charter to be successful:

- A better working relationship between the Private Healthcare sector and government (14 respondents)
- More affordable healthcare (5 respondents)
- Less legislation (5 respondents)
- Better utilisation of healthcare resources (4 respondents)
- Better control of finances and skills (4 respondents)
- Better quality healthcare for the whole country (4 respondents)
- Must be practical to apply in the field. People who work with practical day to day reality must have opportunities to give input on implementation and must be on equal footing (3 respondents)
- PPP only way we can survive (3 respondents)
- Involve all role-players and apply what you learn (2 respondents)
- Get private sector to run state hospitals (2 respondents)
- Get rid of corruption (2 respondents)

The common thread coming through in all three of the above analyses is the necessity for a better working relationship between the private healthcare sector and government and the importance of a successful implementation process. Employers appear to believe that stakeholders do not have sufficient influence and are concerned about the practical roll-out.
**Risk Equalisation Fund**

One of the key steps in the transformation process towards Social Health Insurance in South Africa is the implementation of a Risk Equalisation Fund (REF) which has now been approved by Cabinet. Risk equalisation is a mechanism being put in place to achieve an industry community rate for a common package of benefits. The REF aims to equalise risk across schemes according to various factors. Currently these factors are age, HIV status, chronic conditions linked to Prescribed Minimum Benefits and the birth of a baby within the last twelve months. Schemes will either pay in or receive payment from the Risk Equalisation Fund in accordance with their level of risk related to a benchmark.

Schemes are required to measure these factors and report monthly statistics to the Council of Medical Schemes on a quarterly basis. The implementation of the REF includes a shadow period of monitoring potential monetary flows for the period commencing 1 January 2005. The financial impact on schemes is expected to commence in 2007.

Employers were asked if they understand the concept of the Risk Equalisation Fund:

<table>
<thead>
<tr>
<th>% of Employers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Don’t know/Not sure</td>
</tr>
<tr>
<td>Not stated</td>
</tr>
</tbody>
</table>

It is encouraging to note that 63% of employers say that they understand the REF and this is an indication of the success of the consultation and communication process that has taken place regarding the REF. The fact that most of the SME employers are uncertain about the REF concept is understandable, as the part they play in an open scheme is small, but it is nevertheless important for them to understand the impact, as their employees will be affected by any change in contribution rates brought about by monetary flows into or out of the REF. It is a concern that 5 employers in closed schemes do not understand or are uncertain about the concept of the REF as they may be heavily impacted by the monetary flows.
Similar results from the closed scheme and SME employers were obtained when they were asked if they understand the impact of the Risk Equalisation Fund on their employees’ medical scheme:

We can see that there is clear alignment of understanding of the concept as well as the impact of REF amongst closed scheme employers, with 32 understanding the concept and 33 understanding the impact.

With regard to open schemes there is a mismatch between the conceptual understanding of REF (29 employers) and the understanding of the impact (11 employers). Clearly the challenge to the open schemes is to communicate to stakeholders including participating employers on the possible impact of REF.

The quantification of the monetary amount is key to understanding the impact of REF on any particular medical scheme. Closed scheme employers were asked if they had quantified the monetary impact of the REF on their scheme:

- 31 employers have already done so
- 1 employer says this has not yet been done
- 5 respondents were not sure
Employers were asked if they believe the REF is a positive and workable intervention in the South African context:

**Is the REF a positive and workable intervention in the SA context?**

![Chart showing the percentage of employers' views on the REF]

- **Yes**: 14% (SME), 15% (Open), 9% (Closed)
- **No**: 13% (SME), 13% (Open), 9% (Closed)
- **Don’t know/Not sure**: 18% (SME), 27% (Open), 27% (Closed)

As with some of the other aspects of transformation of the healthcare industry we note that employers are divided with regard to their views on important elements, and many are undecided as to how to comment.

In order to understand the divided views in more detail we probed for comments on their opinions on the likely impact of the REF. The following summarizes the main views expressed by employers:

**Positive impact**

- Will help to equalise the playing fields and standardise benefits (3 respondents)
- Might score because we have lots of pensioners (3 respondents)
- Will stabilise the industry (2 respondents)
- Could be positive for the industry if it helps to keep healthcare affordable (1 respondent)
- Positive - will help schemes to survive (1 respondent)

**Negative impact**

- Unfair to medical schemes who have done a good job of running their scheme well (6 respondents)
- Penalizing funds, not encouraging them to look after their risks, no incentives to perform better (6 respondents)
- Concerned about all the extra administration required by REF - who will carry these costs? (5 respondents)
- Members will be penalized by having to pay more in order to subsidise REF (3 respondents)
- Can’t make our members pay more, may have no option but to move into open scheme environment (1 respondent)
- Smaller closed schemes with good risk profile may have to join open scheme (1 respondent)
- Negative for those who have to pay in (1 respondent)
- Will bleed the reserves of strong funds (1 respondent)
Many of the respondents were undecided as to whether the REF would have a positive or negative impact and 8 respondents said that this would be determined by the implementation process. A train of thought that came through quite strongly is reflected in the following comment:

“Concerned that funds who are doing a good job will now suffer by supporting ones who did a bad job.”

The overriding concern voiced by employers is the belief that schemes will decrease their management of risk as they perceive that there is now less incentive to do so. It was also suggested that funds would purposefully seek out poor risks in order to increase the payments they receive from the REF. This might explain why so many employers are concerned about the risk of fraud in the REF reporting. Overall it is clear that employers believe that the REF will impact negatively on the wealth and morale of schemes that manage risk well. They believe that they have run a tight ship and are now being penalized for it. A number of employers have said that they will have to re-evaluate the viability of remaining a closed scheme.

Although there appears to be some support in principle for the objectives of the REF there is much uncertainty regarding the source of the extra income needed by schemes that must pay in.

62% of respondents gave us details of what they would like to see implemented with respect to the Risk Equalisation Fund:

**REF Do’s**

- Want to understand exactly how it would work and its impact on open schemes (18 respondents)
- Need to set up systems and regular audits to prevent fraud (17 respondents)
- The management and administration of REF must be transparent and beyond reproach (7 respondents)
- Want uniformity of reporting systems and administration minimised to ensure capacity of schemes to deliver data that can be used (7 respondents)
- Government must contribute to REF as well (1 respondent)
- “Rather have a separate closed scheme and an open scheme REF evaluation. That would make more sense.” (1 respondent)

**REF Don’ts**

The main message given by employers is that well run schemes and smaller closed schemes should not be penalized by the REF.

In conclusion it should be noted that although 63% of employers say that they understand the concept of REF, it is clear that there is still much opportunity for education and dialogue concerning the details of the impact on medical schemes, especially with regard to the management of risk.

“For overall it is clear that employers believe that the REF will impact negatively on the wealth and morale of schemes that manage risk well.”
Social Health Insurance

The move towards a Social Health Insurance (SHI) system in South Africa has gained momentum in the two years since the previous survey. In 2003 most respondents were in favour of SHI but had reservations regarding its implementation. They believed that it might not work due to the high incidence of HIV/AIDS, the lack of state funding as well as the lack of good healthcare infrastructure in South Africa.

Besides the movement on REF, where employer opinions have already been explored in depth, the SHI momentum gained spans the following elements:

- a possible Social Health Insurance contribution, which would mean that all South Africans earning above a certain salary would have to make an additional contribution over and above SITE and PAYE. However, the Minister of Finance proposed that the two-thirds tax-free provision be replaced by a monthly monetary cap. This is covered in detail in the Discussion Document on the Proposed Tax Reforms Relating to Medical Scheme Contributions and Medical Expenses released by the Department of National Treasury on 1 September 2005.
- the attempts to expand medical scheme cover for lower income employees
- the publication of the proposed Health Charter for the industry (employer perceptions have already been reported)

The following are the predominant employer views presented on the elements of Social Health Insurance not already discussed:

- SHI could ease the burden of offering a lower income option within schemes
- The success depends on the integration of the private and public healthcare sectors
- No confidence that government can offer low income medical scheme cover at affordable rates at an acceptable level of quality of care
- Employees are not going to pay for healthcare in public sector hospitals unless there is a vast improvement
- SHI will only work with mandatory membership
- SHI will take the pressure off employers in smaller companies
- Employees prefer money in their pockets to benefits
**Transformation continued**

Employer views on the potential impact of SHI were tested with respect to:

### The Company:
- Do not fully understand the implications (9 respondents)
- Unions will not allow it - will protest (7 respondents)
- Not sure how it will impact on us, may have to lower our subsidy (2 respondents)
- People will be very unhappy, especially the higher income group that’s already heavily taxed (1 respondent)
- Would be devastating for my employees (1 respondent)

### The Medical Scheme:
- Don’t know/unsure (26 respondents)
- Do not see this coming through. Cannot see what the payoff would be (1 respondent)
- May have to review rules of employment (1 respondent)
- Might close down (1 respondent)
- The man in the street is not going to be happy about additional cost to his tax bill (1 respondent)
- Puts continued existence of schemes at risk (1 respondent)
- Would not want to still pay for medical aid as well (1 respondent)

### The Healthcare Industry:
- Don’t know/not sure (62 respondents)
- Everyone will be contributing but not sure how it will work (1 respondent)
- Might see influx of new members who previously did not have a medical scheme (1 respondent)
- Tax benefits do not help me, because I don’t have the cash flow (1 respondent)
- A poor state run system and high cost private hospitals - need to find a middle of the road system of 50% state 50% private - skills transferred (1 respondent)
- Might see changes to top-up schemes - not operating as a medical scheme as such (1 respondent)
- None, healthcare providers will still get paid (1 respondent)
Noticeable in each of the previous three blocks of comments are the high percentages of employers who do not understand SHI or are unsure about the likely impact of SHI:

62% of employers do not understand the impact of SHI on the healthcare industry.

This contrasts sharply with the following finding:

100% of employers want to be consulted with regard to the implementation of SHI.

The reasons that all 100 employers gave for wanting such high involvement are:

- Affects employers because it involves their employees (34 respondents)
- Employer has a better idea of affordability for his staff and knows what their needs are (12 respondents)
- Employer pays the subsidy (10 respondents)
- Government must tangibilise cost to employer and know if employers can actually afford it (9 respondents)
- Affects the employer’s bottom-line and profitability (8 respondents)
- Affects employer if employees are disgruntled and affects productivity (8 respondents)
- Must be a partnership with all sides in agreement if it is to work (6 respondents)
- There are cost implications - restructuring of benefits could be necessary (4 respondents)

Employers want a lot more information about the roll-out of SHI in order to understand the transformation of the healthcare industry. They also want to play a part in the decisions taken that affect both employer and employees. 99 of the 100 employers want to be consulted with regard to the level of a possible SHI contribution per employee.

The lack of understanding and the divided views that employers have on important elements of the transformation of healthcare in South Africa suggest insufficient stakeholder education and communication regarding many of the issues, even though policy documents and debates have been in the public domain over the last ten years. There is much opportunity for engagement and dialogue to increase employer commitment to the transformation currently taking place.

“There is much opportunity for engagement and dialogue to increase employer commitment to the transformation currently taking place…”
In 2005 employers are more positive about the sustainability of medical schemes into the future than they were in 2003. 44% of employers believe that medical schemes in their current form will provide a sustainable solution to the healthcare needs of their employees in the future. The change in attitude is reflected in the graph below:

The main reason for the shift in employer perceptions is probably the result of more certainty around Prescribed Minimum Benefits, particularly the approach to chronic medication, HIV/AIDS and the clarification around Designated Service Providers. The Low Income Medical Schemes (LIMS) task group set up by the Council for Medical Schemes may also be creating a positive perception about sustainability as it reflects government recognition of the fact that cheaper solutions are required. The work that has been done on beginning the process of equalising risk across medical schemes would also have contributed to a different outlook, particularly for employers with closed schemes. The fact that we are further down the road with respect to the roll-out of Social Health Insurance in South Africa than we were in 2003, might also mean that employers feel less uncomfortable about the concept of open enrolment and community rating.

When comparing the different outlooks between open and closed scheme employers, this must be seen in the context of the number of schemes in the samples in each of the years:

- Closed schemes: 37 in 2005 versus 26 in 2003
- Open schemes: 42 in 2005 versus 48 in 2003
- SME’s: 21 in 2005 versus 26 in 2003
Percentages of closed scheme employers and percentages of open scheme employers are used to compare the shift in perceptions between the years. The comparisons for the closed and open schemes (excluding SME’s) show interesting results:

Points to note are as follows:

- Closed and open scheme employers portray the same increase in positive perceptions, from 27% of employers in 2003 to 51% (53%) of employers in 2005 indicating that they believe medical schemes can provide a sustainable solution.
- The negative perceptions of open scheme employers have nearly halved, from 63% to 33% of responses

Employers believe that government could implement the following measures in order to provide a more sustainable solution:

- Improved access, standard of service and better management of State hospitals (29 respondents)
- Less State control in public hospitals so that higher quality healthcare becomes available for all South Africans (25 respondents)
- Public Private Partnerships for the State hospitals (18 respondents)
- Subsidised medical care for everyone and cheaper medicines (6 respondents)

“In 2005 both open and closed scheme employers are more positive about the sustainability of medical schemes...”
The 34% of total employers in 2005 who believe that medical schemes in their current form will not be sustainable into the future, indicated that they foresee the following emerging:

**Emerging funding mechanisms**

- Shift from using private hospitals to state hospitals: 20% of employers
- Shift from private healthcare to a social healthcare system: 20% of employers
- Re-emergence of insurance cover for shortfall in medical expenses via Life Insurer or short-term insurer: 11% of employers
- Medical schemes offering only private hospital cover and PMB cover: 10% of employers
- Capitated or network benefits where choice of service provider is limited or restricted: 7% of employers
- Self-funding: 4% of employers
- Medical schemes with supplementary benefits: 2% of employers

Employers were asked to give an indication of their role in the future provision of healthcare cover for their employees:

**Role of the employer in the provision of healthcare cover will:**

- Increase: 24% of employers
- Decrease: 14% of employers
- Remain the same: 11% of employers
- Not sure: 12% of employers
Reasons given by employers for their role increasing include:

- Medical Inflation continues to rise above salary inflation so the employer will have to pay more (23 respondents)
- REF will cause closed funds to take greater ownership and control but it will cost more (7 respondents)
- Government will expect employers to cover all employees (2 respondents)

Reasons given by employers for their role decreasing include:

- Lower subsidies and decrease in benefits are in the pipeline, want to shift more of the risk to employees (8 respondents)
- Want to minimize the risk for the employer (3 respondents)

Of the closed scheme employers who are unsure of their future role in the provision of healthcare, 6 of them have indicated that they are waiting to see what the impact of the Risk Equalisation Fund will be.

**Low Income Market**

In 2005 detail was requested regarding salary levels so that it would be possible to report on the differences between high, middle and low income earners with regard to the provision of healthcare by employers. However the majority of respondents were unable, or unwilling, to give us this level of detail.

22 employers out of the total sample tell us that their entire workforce is covered by a medical scheme, including their low income employees. All of them indicated that membership of a medical scheme is compulsory. 11 of these employers are in the closed schemes market and in total represent 150 100 members.
Future of healthcare in South Africa continued

Employers were asked that if their company currently subsidises or were to consider subsidising low income employees, how they would rate the importance of the following factors on a scale of 1 - 10 where 10 is of extreme importance:

<table>
<thead>
<tr>
<th>Importance of type of cover offered to low income employees</th>
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</thead>
<tbody>
<tr>
<td>Hospitalisation in a private hospital</td>
</tr>
<tr>
<td>Hospitalisation in a public hospital</td>
</tr>
<tr>
<td>Freedom of choice for day to day primary care via a provider of choice</td>
</tr>
<tr>
<td>Day to day primary healthcare via DSP</td>
</tr>
<tr>
<td>Dental Benefits</td>
</tr>
<tr>
<td>Optical Benefits</td>
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</tbody>
</table>

The graph above clearly indicates that employers perceive hospital cover and day-to-day primary healthcare as critical factors for low income employees. There is more support for private hospital cover than for cover in public hospitals and the 8 employers who ranked hospitalisation in a public hospital as critical probably do so from a cost perspective.

It is significant that employers perceive Designated Service Provider networks for primary healthcare as important for this market. These employers sit in the closed, open and SME environments. Dental and optical benefits have not been rated as critical but the above ratings tell us that employers still regard these benefits as necessary.

Prescribed Minimum Benefits and the Low Income Earner

Respondents were asked whether in their opinion, within the context of current lower income products, the current full set of PMB’s is affordable for lower income earners:
Only 28% of employers believe that the current set of Prescribed Minimum Benefits is affordable for the lower income market. This is one of the aspects being examined by the Low Income Medical Schemes (LIMS) task group appointed by the Council for Medical Schemes on behalf of government to investigate a more affordable healthcare solution for low income earners.

**The Low Income Pensioner**

There are predominantly two classes of low income consumer:

- those that are employed but earn too little to be able to afford to belong to a medical scheme (and may or may not receive some form of healthcare cover via occupational health clinics at the workplace), and

- those that are indigent and rely entirely on the State for their healthcare needs.

A third class of low income consumer is starting to emerge in the South African healthcare industry. In the Post Retirement Healthcare section of this report we see how employers have shifted the burden of healthcare costs to the future pensioner, by limiting or removing post-retirement medical scheme funding.

The aged and indigent amongst the above mentioned two classes of healthcare consumers are already a major concern for government owing to the high cost of their healthcare, so it is of even greater concern that another section of the population, previously employed and adequately covered by medical schemes, is starting to add to this burden because employers are no longer willing to provide post-retirement healthcare funding.
Government Employees Medical Scheme (GEMS)

Employers were asked for their opinion on the impact of the new Government Employees Medical Scheme on the healthcare industry.

It is important to note that the questions posed to employers were open-ended and respondents were not led by any prior categorisation of possible answers. The verbatim comments were subsequently analysed and the following summarizes their responses:

Closed Scheme employers

- Can ‘piggy-back’ on GEMS price negotiations (13 respondents)
- Opportunities for cost improvements, especially in hospitals (8 respondents)
- Merger of some schemes (6 respondents)
- Little impact (1 respondent)
- Greater standardization of benefits and costs (1 respondent)
- They will dictate prices to private healthcare due to power of numbers (1 respondent)
- Possible upgraded service in public hospitals and we will be able to benefit (1 respondent)

Open Scheme employers

- Government may start a price war - strong negotiator with a lot of members to force the providers’ hand (7 respondents)
- Fewer schemes (4 respondents)
- Less income for the providers (3 respondents)
- Government hospitals might play a bigger role (2 respondents)
- Smaller industry but hopefully more competitive (2 respondents)
- Massive impact - will push up cost (1 respondent)
- Standardization in the industry (1 respondent)
- Not sure (19 respondents)

SME employers

- The bulk of the SME respondents were not sure of the impact of GEMS.

Respondents were also asked to give their opinion on the impact of the GEMS scheme on their company as well as their company medical scheme or associated scheme. For the open scheme and SME employers the overriding message was that they believed that contributions would increase for those schemes affected by the withdrawal of government service employees. Employers who offer closed schemes do not believe that there would be any impact on their company.
Traditional Health Practitioners Act, 2004

The Traditional Health Practitioners Act, 2004 was published in the Government Gazette in February 2005, in order to legalise and regulate the practice of traditional healers in South Africa. The President still has to fix a date for the new Act to become operative, at which time the recognition of traditional medicine for inclusion in medical scheme benefits will come under review.

Survey respondents were questioned with regard to their opinion of this Act:

- A reality of SA society but must be regulated and controlled to ensure no rip-off (21 respondents)
- Concerned about the standard and qualifications of the people and who would regulate them (19 respondents)
- Good idea if registered - employees would have some protection which they do not have now (12 respondents)
- Know very little about it - not sure if or how it would work (12 respondents)
- Don’t believe it should be included, no research to show proven outcomes (9 respondents)
- No fee structure or system to determine provider pricing, must prevent current abuse (7 respondents)
- Administration difficulties because they do not have high levels of technology (4 respondents)
- Concern that absenteeism is abused by Sangomas (2 respondents)

“if they are accredited and have a medical register I see no difference between them and homeopaths. Will need to prove their clinical outcomes”.

The respondents were also questioned with regard to the likely impact of the Traditional Health Practitioners Act on the company, the scheme and the industry, and the following were the most common trains of thought:

- Employers are particularly worried about the practicalities of:
  - long periods of absenteeism currently experienced when employees seek the advice of Traditional Healers
  - the monitoring of sick notes and down-time
  - the need to limit benefits so that it is not an open cheque-book
  - double costs because employees still go to ‘Western’ doctors
  - fraud
- For schemes the extra claims and higher costs as well as fraud and corruption are the key issues
- For the industry the duplication of consultation costs and increased hospitalisation as a result of traditional healer mistakes are seen as the main concerns.
Since the first survey in 1994 we have noted the trend towards excluding pensioners from company funding for healthcare. 1995 showed that 89% of companies surveyed were providing funding of health benefits for pensioners, compared with 2003 which revealed that only 43% of companies surveyed were assisting with funding pensioner healthcare costs. The trend towards excluding pensioners from company healthcare funding continues, with only 29% of respondents indicating that they currently offer some form of post-retirement subsidy in 2005. However, respondents were cautious about revealing their stance on pensioner funding and not all employers responded to this question. It is therefore uncertain whether the percentage of employers funding post retirement healthcare has already moved to this low level.

Where respondents were prepared to give an indication of the basis of employer funding for post-retirement medical contributions we can clearly see that 42 employers provide no post-retirement healthcare funding whatsoever.

Company philosophy towards the funding of pensioner healthcare for those employers that released information reflects the following strategies:

- To limit the company liability by imposing limitations on employer contributions
- To limit company liability by changing medical scheme benefits
- Other
- Cash in lieu of post-retirement cover

It is interesting to note that in 2003, 19% of the employers surveyed were considering cash in lieu of post-retirement cover as a strategy in order to tackle their post-retirement liability. No respondents have indicated this philosophy in 2005. Over the two years since the 2003 survey, there have been a number of legal challenges against companies that have attempted to change or remove the pensioner healthcare subsidy and this would have made employers cautious about following this strategy. If they do decide to follow this route the involvement of legal opinion tends to protract the process and this may be another reason why we see no respondents indicating this approach at the present time.
Another strategy adopted by employers is that of reducing the post-retirement liability by offering enhanced pensions:

2 employers say that they have already done this
4 employers say that they intend to do so
4 employers say that they are currently investigating this strategy

These 10 employers are already included in the numbers reflected in the above graph showing the philosophy towards current pensioner healthcare funding.

**Post-Retirement Healthcare Liability**

It is now mandatory for companies to reflect their pensioner healthcare liability in their financial statements. This amount must cover the company liability in respect of current pensioners on the medical scheme, as well as the liability in respect of any post-retirement contributions for future pensioners if the company still provides this benefit to its employees. In some cases companies only provide this benefit to employees who joined the company before a certain date.

The funding of the post-retirement liability was explored with those employers that contribute towards pensioner healthcare funding. It must be remembered that 42 employers have said that they provide no post-retirement funding and there are thus no responses from these employers. The following responses were received:

38 employers in total have either already set aside funds, are in the process of setting funds aside or intend to do so. 11 have already set aside the full amount to cover this specific liability. In 2003 there were 16 employers who had set aside the full amount.
Funding vehicle used for post-retirement healthcare

10 closed scheme employers still use the company medical scheme as the vehicle to fund the post-retirement liability, even though the Council for Medical Schemes has made it clear that funding of this liability may not occur within a medical scheme.

The IAS19 (AC116) Accounting Standard

The move towards excluding pensioners from post-retirement healthcare benefits started in 1997 with the introduction of the accounting standard that required the post-retirement medical scheme liability to be shown in company financial statements. Although not mandatory at the time, it created an awareness of the potential size of the liability that would impact on company balance sheets. Over the ensuing 8 years we have seen how employers have reduced their share of the cost of pensioner healthcare in a number of ways:

- Excluding healthcare benefits in retirement from the employment contracts of all new employees
- Capping employer contributions for all future as well as existing pensioners
- Offering cash or other benefits in lieu of continuing to cover the liability of post-retirement medical scheme contributions
- Re-designing the medical scheme benefit structure or imposing limitations on benefits.

Now that the IAS19 (previously AC116) pensioner liability is mandatory, we asked employers whether in their opinion the amount reflected on the company balance sheet truly and fairly reflects the company’s liability. Of the 46 respondents who have indicated that they do have a liability in 2005, only two indicated that they were unsure and the balance indicated that the amount is a true and fair reflection.

Healthcare cost-shift to Pensioners

An overriding concern for the healthcare industry is the fact that over the past decade many employers have dealt with the high cost of funding for pensioners by removing a significant portion of this liability - at least the cost of funding future pensioners and in some cases the cost of funding present pensioners as well. The total liability in respect of present pensioners may not have been entirely removed but it has been heavily capped by the vast majority of employers. This means that fewer pensioners will receive medical scheme contributions from their employers and the burden of paying for healthcare in retirement may be shifted entirely onto them.

Unless the cost of healthcare within medical schemes can become more affordable it is unlikely that the average pensioner will be able to self-fund the full contribution, either in open schemes, or within closed schemes. They are then forced to give up their medical scheme membership, unless their particular scheme is able to reduce the level of member contribution as a result of becoming a net recipient of funds from the REF. This is a different type of low income consumer who inevitably also becomes a burden on the State, in addition to the other two classes of low income consumer addressed in the section covering the Future of Healthcare in South Africa.

“These pensioners are a different type of low income consumer who inevitably also become a burden on the State...”
Voluntary versus compulsory membership

In 2003 it became clear that the choice of offering voluntary or compulsory membership to a workforce is a key factor in influencing the number of employees who join a medical scheme. Even where membership of a medical scheme is compulsory (a condition of employment) there is a percentage of employees who remain without cover due to lack of affordability. This means that employees sometimes forego the employer subsidy because they cannot afford the total contribution.

The 2005 sample of respondents shows that for 51% of employers, medical scheme membership is compulsory. This result is higher than 2003 (where 39% of respondents indicated that membership was compulsory) and has been influenced by the greater percentage of closed schemes in 2005, where membership is often a condition of employment. In the Low Income section of this report (found under Future of Healthcare) we learn that 22 employers say that their entire workforce is covered by a medical scheme, including their low income employees. When we compare this with the above statistic we see that less than half of the compulsory membership employers are able to say that all their employees have cover.

In 2005 there is an additional category of employers as a result of the detail we requested regarding salary levels. This shows that 13% of employers make membership compulsory only for certain salary categories: this is not only higher salary earners as the detail reported shows that for some employers it includes workforce earning R2500 and above.
Of the 51 employers who offer compulsory membership the following graph shows that 27 of these employers are in the closed scheme environment and 32 employers in total offer employees only one scheme. The balance of the breakdown between SME, open and closed scheme respondents and the range of choice of schemes are shown in the graph below:

**Compulsory membership - scheme choice**

- No choice - only have one scheme
- Yes - choice between two schemes
- Yes - choice between more than two schemes

<table>
<thead>
<tr>
<th>Scheme Choice</th>
<th>SME</th>
<th>Open</th>
<th>Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>No choice - only have one scheme</td>
<td>1</td>
<td>5</td>
<td>26</td>
</tr>
<tr>
<td>Yes - choice between two schemes</td>
<td>3</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Yes - choice between more than two</td>
<td>4</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

Of the 36 employers who offer voluntary membership there is greater choice of schemes for employees but more than half offer only one scheme to their workforce. The preference for a single scheme even in a voluntary membership environment is interesting and is possibly driven by the need for ease of administration:

**Voluntary Membership - scheme choice**

- No Only have one scheme
- Yes Choice between two schemes
- Yes Choice between more than two schemes

<table>
<thead>
<tr>
<th>Scheme Choice</th>
<th>% of Employers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Only have one scheme</td>
<td>20</td>
</tr>
<tr>
<td>Yes Choice between two schemes</td>
<td>6</td>
</tr>
<tr>
<td>Yes Choice between more than two</td>
<td>6</td>
</tr>
</tbody>
</table>
For the 13 employers who make membership compulsory only for certain salary categories 6 offer one scheme and 7 offer more than one scheme.

In comparison with 2003, where a total of 54% of employers offered only one scheme to their employees, we see that in 2005 a total of 58% of employers do so (32% in a compulsory membership environment, 6% where membership is compulsory above a certain salary level, and 20% in a voluntary membership environment).

Of the total sample of 100 employers there are 8 employers who offer 4 schemes and 6 employers who offer 5 schemes or more. This is a large number of schemes to expect employees to understand and it is thus not surprising that member education has emerged as a key strategic issue during the 2005 survey.

**Reasons for offering membership in an open arrangement**

The following are the reasons given by employers for choosing an open scheme environment:

<table>
<thead>
<tr>
<th>Reason</th>
<th>% of Employers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offers employees a range of options</td>
<td>29</td>
</tr>
<tr>
<td>Do not meet the Registrar of Medical Scheme requirements</td>
<td>29</td>
</tr>
<tr>
<td>Healthcare not a core business</td>
<td>22</td>
</tr>
<tr>
<td>Providing competitive and market related schemes to our employees</td>
<td>18</td>
</tr>
<tr>
<td>Pressure from employees to have access to open schemes in the market</td>
<td>13</td>
</tr>
<tr>
<td>More cost effective</td>
<td>12</td>
</tr>
<tr>
<td>Greater flexibility</td>
<td>9</td>
</tr>
<tr>
<td>Remove risk from the company</td>
<td>6</td>
</tr>
<tr>
<td>No pensioner members—wanted benefit of paying lower premiums in the open scheme market</td>
<td>4</td>
</tr>
</tbody>
</table>

“**Member Education emerges for the first time as a key strategic issue for employers...**”

Lydia Footman
Risk Manager
In 2003 the ability to offer employees a range of options was also the top reason given for offering membership in an open arrangement, with the second reason being that employers did not see healthcare as their core business. The third reason given in 2003 was that it was more cost effective to offer membership in an open scheme environment.

An interesting new trend emerges in 2005: 18 employers rate providing competitive and market-related schemes to their employees as a reason for choosing an open scheme environment and 13 employers say that they experience pressure from employees to have access to open schemes in the market. This denotes the power of consumerism and the need for employers to give their attention to this aspect in striving to be an employer of choice.

**Reasons for choosing a closed scheme environment**

The graph below reflects the main reasons for employers choosing a closed scheme environment:

In 2003 maintaining control over costs was also the top reason given for offering membership in a closed scheme environment, and lower risk exposure was also rated second, as is the case in 2005. There is thus clear indication that closed schemes are seen as a risk mitigation tool for employers. The third reason given in 2003 was that employers could maintain control over benefits (fourth in 2005) and ‘historical reasons’ was the fourth reason given in 2003 (third in 2005) for choosing a closed scheme environment.
Employers were asked to give the advantages and disadvantages of being in an open or closed scheme arrangement:

**Open scheme environment:**

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater choice for members (43)</td>
<td>Lack of control over contribution increases (42)</td>
</tr>
<tr>
<td>Better service to members (22)</td>
<td>Lack of control over cost increases (41)</td>
</tr>
<tr>
<td>Less administrative hassle (13)</td>
<td>Reduced negotiating power on admin. fees (17)</td>
</tr>
<tr>
<td>Staff must be content and receive professional treatment (12)</td>
<td>Higher risk (7)</td>
</tr>
<tr>
<td>Lower cost to company (7)</td>
<td></td>
</tr>
<tr>
<td>Less risk to company (4)</td>
<td></td>
</tr>
</tbody>
</table>

The advantages of open schemes sees consumerism once again playing a role in employer perceptions, to a larger extent than in 2003 where greater choice for members was placed second to less administrative burden which was the top advantage identified then. Better service to members has moved from fourth place in 2003 to second place in 2005. Indications are that employers believe that they are giving employees what they want by choosing an open scheme environment but there is full recognition that in the long term this may not be in the interests of employees, because lack of control over contributions and over cost increases are the main disadvantages cited by employers. These are the same top disadvantages identified in 2003.

**Closed scheme environment:**

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better able to manage risk (22)</td>
<td>Limited options available to members (29)</td>
</tr>
<tr>
<td>Maintain control over benefit design (17)</td>
<td>Management time and input (25)</td>
</tr>
<tr>
<td>Control over administration (16)</td>
<td>Detracts from core business (5)</td>
</tr>
<tr>
<td>Maintain control over costs (13)</td>
<td>Lower economies of scale (4)</td>
</tr>
<tr>
<td>Internal equity amongst employee bands (9)</td>
<td></td>
</tr>
</tbody>
</table>
It is clear from the above that greater control over four key aspects is what drives employers to choose closed schemes:

- control over managing risk
- control over benefit design
- control over administration
- control over costs

These were also the main advantages identified in 2003, together with cheaper administration costs for closed schemes. Employers in both 2003 and 2005 recognize that employees have less choice inside a closed scheme, and in 2005 the amount of time and input from management emerges as a key disadvantage. The role of trustee takes a considerable amount of time and effort and employers are concerned about this.

Advice sought by Employers

The graph below shows the areas of medical scheme management where employers are currently seeking advice as well as to what extent this advice is sought:

Level of advice sought

The fact that HIV/AIDS and employee education are the areas where the most extensive professional advice is sought is not surprising, considering the findings documented on these two areas elsewhere in this report. It is interesting that SHI features as an area where four employers say they seek daily advice, but perhaps this is not unlikely when one considers that 100% of employers want to be involved in the path towards Social Health Insurance. The 3 employers seeking daily advice on prefunding are possibly busy with an actuarial valuation of their post-retirement healthcare liability.
The growth of managed care initiatives has been tracked since the first Old Mutual Healthcare survey in 1994. At that time 43% of respondents indicated that managed care would form part of their future plans to reduce healthcare costs and this percentage gradually increased over the decade that followed.

Managed care in South Africa takes many forms. It started as a collection of cost-control tools that schemes implemented incrementally, such as chronic medicine pre-authorisation and management, the pre-certification of hospital admissions, case management of potential high-cost hospital patients and various disease management programmes. Some medical schemes also entered into contracts to manage specific disciplines like dentistry, optometry and pathology and the use of various networks of providers in some of the disciplines commenced. Gradually preferred provider networks were introduced into scheme benefit structures and the introduction of Designated Service Providers has increased this aspect of managed care in the last two years. The extension of Prescribed Minimum Benefits to cover 25 chronic conditions prompted an increase in the development of medicine formularies, and the strategic focus on managing HIV/AIDS over the last five years has resulted in widespread use of HIV/AIDS management programmes.

Tracking the development of managed care since the 1994 survey needed to accommodate the changes described.

In 1997 employers identified managed care as the leading strategy for controlling rising healthcare costs.

By 1999 88% of employers surveyed had implemented chronic medicine management programmes and hospital pre-authorisation procedures, with 73% having implemented hospital case management.

We saw disease management programmes grow from a zero base in 1997 to implementation by 53% of respondents in 2001.

By 2003 we noted widespread implementation of hospital and pharmacy benefit management programmes and these elements had become standard services that one would expect a scheme to use. They were no longer included in the list of managed care elements measured in the survey.

Disease management programmes were in place with 59% of respondents by 2003, centralised buying of chronic medication was in place with 54% of respondents and preferred provider hospital networks were implemented by 38% of employers.

The above examples of managed care were often purchased individually in the early years and schemes entered into a number of contracts. More recently schemes are inclined to purchase a “packaged” managed care solution from one managed care organisation. Perhaps because of this all the elements of the solution are not necessarily well understood by an employer. Certainly employers in open schemes may not be familiar with all the aspects of the managed care package in place for their scheme.

In the 2005 survey less than 30% of employers responded to the managed care section. In responses where employers did identify the specific managed care services and wellness initiatives we noted a large divergence of views and it would appear that employers are possibly no longer certain about the effectiveness of managed care initiatives. Where employers were asked what actions they have taken or will take, the following responses were received:
It is worthwhile commenting on perceived trends amongst the employers who responded to this section of the survey:

- Disease management programmes are still very popular. It should be remembered that the Prescribed Minimum Benefit implementation may well have encouraged more management of various conditions, particularly as the PMB’s were substantially extended from 1 January 2004 to include the Chronic Disease List. The treatment of HIV/AIDS as part of PMB initially covered only opportunistic infections, but with effect from 1 January 2005 now also covers anti-retroviral treatment. HIV/AIDS management programmes are used extensively.

- The high cost of healthcare at older ages is mostly due to the prevalence of chronic disease (often multiple conditions in the same patient) and so it is likely that disease management will continue to play an important role, specifically with respect to high-cost patients.
• Wellness incentives are in place for almost 50% of the respondents. It would appear that there is still interest from employers in corporate wellness initiatives. This was a trend identified in the 2003 survey.

• Centralised buying of chronic medication seems to have decreased considerably since 2003 as 65% of the respondents tell us that they have no intention of implementing this. In 2003 it was the second highest managed care initiative already implemented, following disease management (remember that the implementation of hospital and pharmacy benefit management programmes was no longer measured from that year). The implementation of single exit pricing for medicines is assumed to be one of the main reasons that centralised buying of chronic medication is no longer seen as a key managed care tool.

• The utilisation of preferred provider networks of specialists and hospitals are beginning to emerge but nearly 70% of respondents say that they do not intend to put these in place. Negotiations with preferred provider networks could possibly have been influenced by the need for schemes to first implement Designated Service Providers for Prescribed Minimum Benefits. Respondents may not view these arrangements as preferred provider networks.

• Risk-sharing arrangements with providers do not yet appear to be popular and it would seem that there is little intention to move in this direction, but owing to the low response rate no conclusions can be drawn.

Although no further managed care trends emerge in the 2005 survey, the following employer perceptions are worthy of note:

• Employers say that they rely on the administrator or the managed care organisation when it comes to educating employees about managed care.

• Preferred provider networks that do not have wide coverage across the country are extremely difficult to implement.

• Medicine formularies of preferred providers are perceived by members as restrictive because certain medicines used by them in the past are not covered.

• More education is needed to teach members about the benefits of joining disease management programmes.
Contributors

Thank you to the following employers who took the time to provide us with such valuable information and perceptions:

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Clover South Africa
CSIR
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Eskom
Eureka Transport
Gariep Motors Kimberley
Grintek Electronics
Group 5
Halls
IBM South Africa
Interstate Bus Lines
Kimberley Municipality
Klerksdorp Medical Benefit Society (KDM)
Letaba Brickyard
Matsumi Sawmills
Mbombola Municipality
Micro Healthcare
Mpumalanga Managed Health Care (Pty) Ltd
Potchefstroom Municipality
Provincial Legislature
Record Stone
SA Post Office
Sasol South Africa Limited
Shoprite Checkers
Siemens
South African National Parks Board
South African Reserve Bank
Southey Street Motors
Sovereign Motors
Telkom Limited
Tiger Brands
Total South Africa
Transmed
UNISA
University of the Free State
Witbank Municipality