

12 Civil Service Medical Scheme Cover

12.1 Background

There are roughly 400,000 civil servants covered by medical schemes out of a total of 1 million. Medical scheme cover is available to civil servants on a voluntary basis and they are not compelled to take up membership. For those that do, two-thirds of their contribution is subsidised. Those without cover fall typically into lower income categories.

The group in cover makes use of open medical schemes, where substantial intermediary costs (brokers) and excessive administration fees are paid. A risk pool with 1 million principal members is so large, however, that consideration has to be given to options where the combined purchasing power of such a group can be maximised to obtain more cost-effective cover. Substantial savings are however possible, through:

- More efficient purchasing of health services;
- The lowering of administration costs; and
- The elimination of unnecessary intermediary (broker) commission-related expenses.

Any group-related solution to bringing all civil servants into medical scheme cover will invariably impact on potential models of service provision in the private and public sectors. Depending on its structure it could also serve to dampen upward trends in administration and other intermediary costs.

12.2 Concerns with the Status Quo

Medical scheme coverage for civil servants has emerged from a period in which Government as an employer played only a small role in actively planning health benefits for members. Consequently, coverage is incomplete, expensive and increases each year by around twice the general inflation rate. The public sector as an employer is experiencing significant cost increases that it has no influence over.

12.3 Discussion of Options

The reform of medical scheme cover for civil servants presents an opportunity to Government to generate socially acceptable and viable forms of health cover and provision generally within the medical schemes environment. The management and reform of cover for such a large group will inevitably expose inefficient and over-priced private sector business models; both in terms of health service provision, administration fees and markets for intermediary services.

12.3.1 Co-ordination of Civil Service Access to Health Cover and Services

Coverage of a group as large as 1 million principal members and a further 2 million dependants requires strong oversight by Government as an employer, strong representation by employees, as well as strong governance of whatever form of cover is eventually chosen. A designated structure should therefore be considered that serves this purpose.

This structure would need to be representative (employer and employee) and potentially have, *inter alia*, the following responsibilities:

- Design and implementation of medical scheme cover for employees;
- Make recommendations on subsidies to employees and those who have retired;
- Mandate cover for civil servants;
- Oversee the accreditation of medical schemes; and
- Design and implement a restricted membership scheme for public sector employees

12.3.2 Mandating Cover for Civil Servants

As voluntary membership of medical schemes results in adverse selection, it is appropriate to move toward mandating cover for all civil servants. However, in introducing such a mandate, acceptable cover would have to be created for lower-income civil servants (i.e. those presently without significant cover). It would be inappropriate generally to compel civil servants to join poorly managed and over-priced medical schemes.

12.3.3 Restricted Medical Scheme: Proposal

Existing open medical schemes do not have the specific interests of public sector employees in mind when decisions are made concerning benefit costs, payment of intermediaries and the type and quality of administration.

As the majority of civil servants presently not covered are low-income earners, the cost and benefit management of their cover will be essential to creating acceptable and affordable options for them. The most feasible method for ensuring that cover can be obtained at reasonable cost for this group, and even civil servants in general, is to establish a dedicated low-cost restricted membership scheme for public servants.

This scheme would be registered with the Council for Medical Schemes and focus on the needs of public servants and their dependants. In this way the interests of civil servants will be reflected in the decisions of scheme management.

The Medical Schemes Act makes provision for the governance structures of all medical schemes. Schemes must have at least 50 percent of the board of trustees elected from the scheme membership. This permits the appointment of government and employee representatives (who must be scheme members) as well as generally elected membership onto the board of trustees.

The establishment of a restricted membership scheme of this type will ensure that the buying power of upward of 500,000 principal members can be used to purchase cost-effective administration services and high quality, low cost medical benefits.

This scheme could eventually be opened up to general enrolment and even become the “state-sponsored” scheme discussed in **section 11**.

12.3.4 Restricted Medical Scheme: Benefit Options

Low-cost medical scheme options can be defined in various reports as those offering an “essential” package of benefits (as discussed in the monograph), and costing less than R1,000 per month for a family of four with earnings of R4,000 per month or less. Note that in 2001, 53.7 percent of medical scheme members earned less than R4,000 per month.

An analysis which considered 166 options from 32 open schemes, identified 41 options as fulfilling the low-cost criteria. (Ranchod *et al*, 2001a and 2001b).

The most important way low-cost options improved affordability in recent years was to use *capitated* primary care.

The industry will probably need to break through the R500 per month barrier in product design in order to satisfy the goal of affordable healthcare.

It is in the area of hospitalisation benefits that most work needs to be done in the development of low-cost options. It is our opinion that a key element of contracting with either public or private sector hospitals will be to enter into risk-sharing arrangements, rather than traditional fee-for-service.

Our recommendation for low-cost option design is to consider the following:

- Hospitalisation offered in differential amenities in a public hospital.
- Specialist services in a public hospital.
- Chronic medicine offered either in the public hospital or with a strict formulary by the primary care providers.

- Primary care offered in private sector capitated networks.

12.3.5 Restricted Medical Scheme: Administration and Intermediary Costs

The selection of an administrator is by law determined by the independent management of the medical scheme and not any other party. A scheme with upward of 2 million beneficiaries will be strongly placed to negotiate reasonable administration costs.

One important benefit of a restricted membership scheme will be the removal of any need to pay commission-related fees to brokers operating within the open scheme environment. Many administrators are paying at least 6 percent of Gross Contribution Income (GCI) just to prevent brokers from removing members from their scheme. This is equivalent to the value of a full administration service.

12.3.6 Accredited Medical Schemes and Limitation of Choice

Many open schemes are expensive and do not provide reasonable cover for health benefits. The reduced cover is often difficult for the general public to see, something that is not necessarily accidental. It is therefore recommended that the co-ordinating structure discussed in **section 12.3.1** establish accreditation criteria to qualify a set number of open medical schemes that can serve as alternatives for the restricted membership scheme.

Employees could either be restricted to the accredited schemes. Alternatively the subsidy could be limited to only those schemes which have been accredited. Such accreditation should occur on a provincial basis, to take advantage of schemes that have established lower-cost relationships with hospital and primary care network providers.

12.3.7 Equitable Subsidy System

A contribution subsidy is presently paid by the employer as a fixed 2/3 of the gross contribution payable, irrespective of the scheme chosen. This subsidy should be capped based upon the general desirability of the scheme chosen and the circumstances under which it is chosen. Consideration could therefore be given to subsidising member contribution taking account of the following:

- The income of the member.
- Whether or not the scheme is accredited (where members are not limited to a set number of schemes).
- The subsidy system could be used to counter adverse selection where a number of scheme options are available to members.

12.3.8 Funding the Post-retirement Subsidy

The post-retirement subsidy is contingent upon the subsidy provided to current employees. The primary question for Government is whether this post-retirement liability needs to be fully funded or dealt with on a pay-as-you go basis. Pre-funding the liability does not appear a logical route to follow, given that this approach will not in any way alter the underlying risks associated with liability. Such an approach will merely attract intermediary charges, and administration fees. This approach is however different to approaches required by employers in the private sector, where the liability is reflected on their balance sheet, and where some uncertainty may arise concerning the ability of the employer to fulfil its obligations.

12.3.9 Regionalisation

Schemes that wish to implement capitation options, or negotiate cost saving approaches with service provider networks, are best able to do so if their membership is strongly concentrated within designated regions.

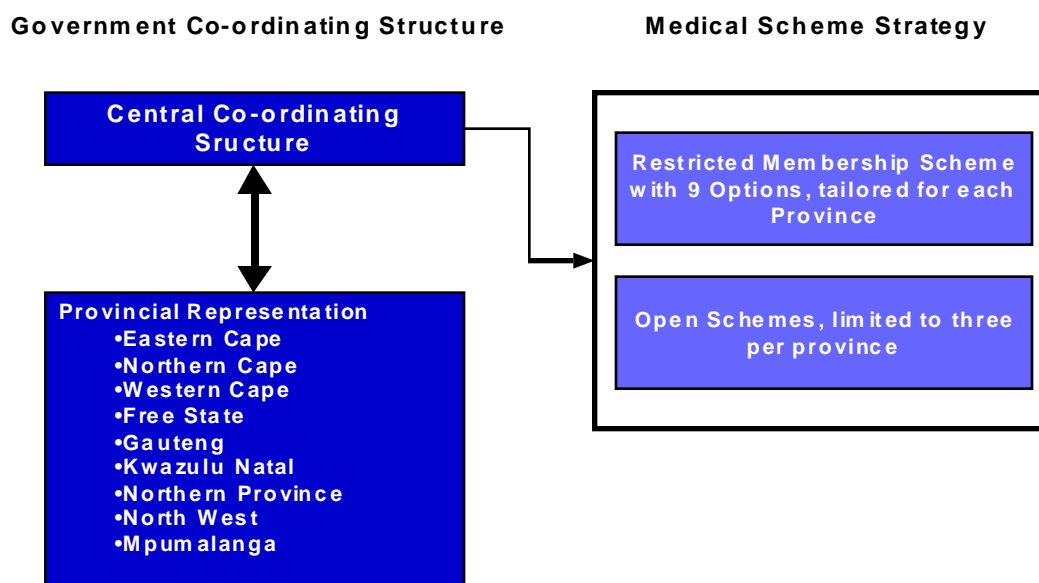
As scheme membership could be made available to civil servants via a limited accredited group of open schemes, and a specific restricted membership scheme, consideration needs to be given to a regional approach to both strategies.

Where schemes are accredited, these could be specific to each province. Thus the three accredited schemes in the Western Cape may be different to the three schemes selected in Free State. This would allow Government to utilise those open schemes that are able to incorporate regional approaches in their product design. This could also form part of the accreditation criteria.

The restricted membership for civil servants could also be regionalised with options created that are province specific. Thus the scheme remains a national scheme, but civil servants join the option appropriate for their province. It will therefore become a condition of employment that members must join the option designed for their province.

Regional representation in the formulation of medical scheme strategies will be very important to ensure legitimacy and to make recommendations on alternative strategic approaches. This should probably not occur within the scheme(s) but occur instead through the central co-ordinating structures set up to oversee the civil service policy as a whole.

Figure 12.1: Regional Structures for Civil Service Medical Scheme Strategy



12.3.10 Relationship to a Risk-Equalisation Fund

Removing the artificial cost advantage one scheme may have over another due to their demographic profile is best managed through a risk-equalisation fund/mechanism. The medical scheme arrangements created for the civil service should become subject to the risk-equalisation approach discussed in **section 11**.

12.3.11 Options in Relation to an Open State Sponsored Scheme Option

The development of a low-cost restricted membership scheme for civil servants will create a sound basis for the general development of low-cost medical scheme cover. It will achieve this through allowing the development and testing of low-cost primary care and hospital options that would prove difficult to achieve within the existing open scheme market.

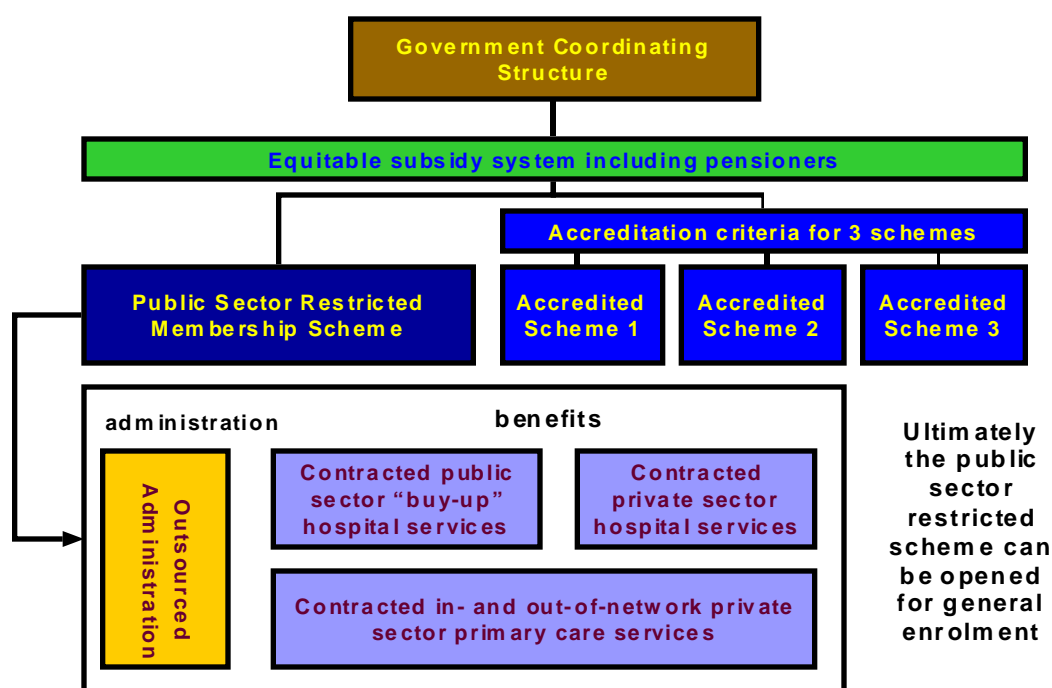
The civil service restricted membership scheme could eventually be made available to general enrolment. This scheme could either become the state-sponsored medical scheme discussed in **section 11**, or operate alongside it. The extension of this scheme into the open market will provide the opportunity for members of traditional schemes to take advantage of pre-negotiated regional network arrangements and benefit options.

12.4 Strategic Direction

12.4.1 Overall Framework

The strategic approach would see the establishment of a government co-ordinating structure, with provincial representation from both the employer and employees. This structure would determine the subsidy system for all civil servants. It would also set up and see to the registration of the restricted membership scheme and develop its benefit options. The co-ordinating structure would also develop, negotiate and implement the accreditation mechanism for a limited number of medical schemes per province. (See **figure 12.2**).

Figure 12.2: Framework for Universal Contributory Cover for Civil Servants



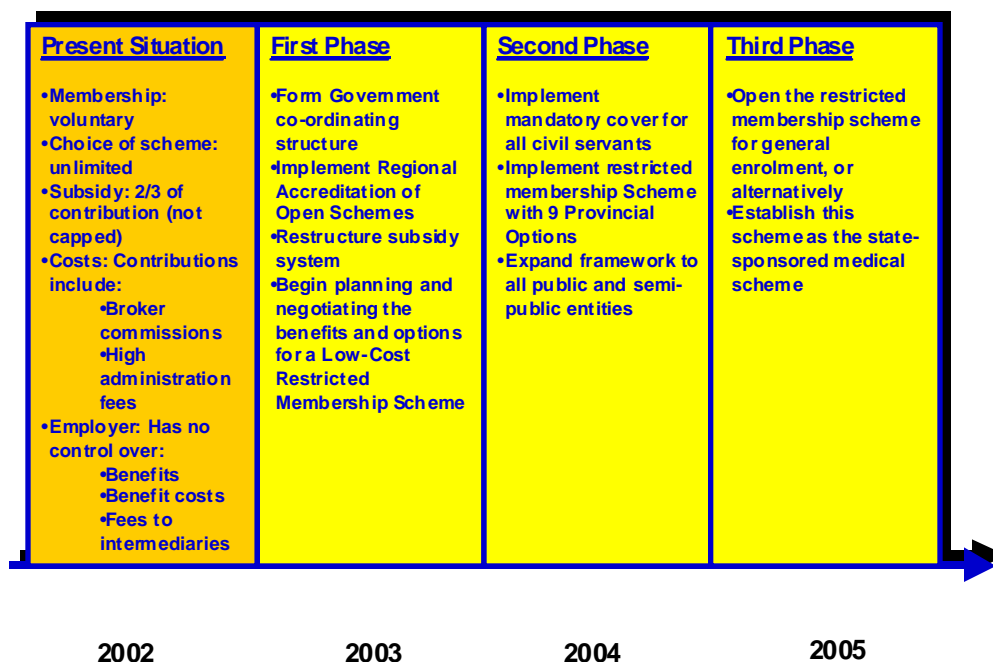
12.4.2 Potential Timelines

The implementation of such a reform would require fairly detailed planning. However, it should be possible to achieve this in a period of roughly three years. (See **figure 12.3**).

- o *First phase:* This would see the implementation of the government co-ordinating structure, and the establishment of a limited number of accredited medical schemes per province. It would also see the negotiation and design of the restricted membership scheme.

- o *Second phase*: This would see the implementation of the restricted membership scheme and the introduction of mandatory universal cover for all civil servants. The restricted membership scheme would have 9 options, one for each province. The overall framework could be expanded to all public and semi-public institutions.
- o *Third phase*: The restricted membership scheme could be initially expanded to incorporate all public and semi-public institutions. This could ultimately lead to the opening up of the scheme to general open enrolment. The scheme could also become the proposed state-sponsored scheme discussed in **section 11**.

Figure 12.3: Timelines for Implementation of a Strategy for Universal Medical Scheme Benefits for Civil Servants



12.5 Concluding Remarks

The development of universal medical scheme cover for civil servants is probably one of the most important immediate health system opportunities within the short-term. It will provide the impetus for the creation of low-cost models of health service provision in the private market, and help develop opportunities for public hospitals to make surplus capacity available to medical schemes

Within a broader reform context, the proposed restricted membership scheme for civil servants could ultimately be made available for general enrolment and take on the role of the state-sponsored medical scheme proposed in **section 11**.