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Saint Lucia

Issues related to universal health care coverage in Saint Lucia

International Labour Organization
Financial, Actuarial and Statistical Services Branch
Social Protection Sector

Saint Lucia Government Task Force on National Health Insurance

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Foreword

The Prime Minister's Special Task Force on National Health Insurance, Farmers' and Fishermen's Pensions, and Unemployment (hereafter referred to as the Government Special Task Force), requested the International Labour Office to provide technical assistance on policy issues relating to the extension of social insurance for the people of Saint Lucia. This trust-in-fund project between the ILO and the Government of Saint Lucia is entitled 'Feasibility study on the introduction of national health insurance, unemployment insurance and farmers' pensions in Saint Lucia' and comprises three distinct studies on each of the themes under review.

Ms Monica M. Burns, senior expert on health insurance policy, and Mr Pierre Plamondon, senior actuary of the ILO Social Protection Sector, prepared the technical substance on health insurance. They visited Saint Lucia in January 2003. Background material provided by national counterparts has been incorporated into the present report, for which the ILO Financial, Actuarial and Statistical Branch is responsible. This report should be read in conjunction with the Government of Saint Lucia's document (2002) on health sector reform proposals, the forthcoming (2003) *Universal Health Care Report* being prepared by the Government Special Task Force and with other ILO technical reports on this project. Annex 1 lists the documents consulted.

In the making of this report, detailed discussions were held with a wide range of national stakeholders, including the Chairperson of the Government Special Task Force, the Chairperson of the National Health Insurance Sub-Committee and those listed in Annex 2, as well as in-depth consultations with Ms Emma Hippolyte, Director of the National Insurance Corporation, and Dr Stephen King, member of the Government Special Task Force. Preliminary findings were presented to and validated with key contacts, including the Prime Minister, the Minister of Health and the Government Special Task Force, whose comments have duly been taken into consideration.

This report focuses on bringing an international perspective, highlighting the pros and cons of proposed reform options and contributing some pragmatic tools on universal health insurance to the proposals already formulated by the Government Special Task Force. In line with the report's mandate, attention is paid to the design of a workable time-scale and the essential basics prior to implementing universal health insurance in Saint Lucia. Strategies concentrate on the introduction of a universal health insurance and on organizational prerequisites in the health care delivery system rather than on implementation.

Given the significant collection, collation and analysis of available data already undertaken by the Health Reform Group and the Government Special Task Force relevant to health insurance, background data is not presented in detail here. Data provided in the context of the studies conducted by the Health Research for Action (HERA) group have been taken as the baseline, according to the general broad scope of the present report and its focus on strategy. It is recommended that a more detailed and accurate system of data collection should be developed. This would provide the information necessary for further refinement of the studies on health insurance costing. At the same time, it would help to achieve the performance targets set out in the health reform programme to modernize and re-focus the health system in Saint Lucia.

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Note to readers

It has been agreed with the Government Special Task Force to use the ILO terminology “universal health insurance” (UHI) interchangeably with the term “universal health care” for the purposes of the present report.

Abbreviations and acronyms

GDP	Gross domestic product
Government Special Task Force	Prime Minister's Special Task Force on National Health Insurance, Farmers' and Fishermen's Pensions and Unemployment and National Health Insurance Task Force
HERA	Health Research for Action group
ILO	International Labour Office
MOH	Ministry of Health of Saint Lucia
NIC	National Insurance Corporation of Saint Lucia
UHI	Universal health insurance
WHO	World Health Organization

Executive summary

The Government of Saint Lucia is committed to improving access to health care for all its citizens. Developments in the health system (in terms of management, equipment, and services) have not kept pace with economic developments over recent years. There is a strong commitment to strengthening the health system – not only to provide the right services to the population but to provide those services in appropriate settings, based on the concepts of solidarity, equity, efficiency and effectiveness. The desire to have a modern, responsive health care delivery and financing system has to be balanced against the small size of the population and their financing capacity. In a small country with a not yet fully developed economy it will never be logistically possible, economically efficient and financially feasible to provide all clinical services. Hard choices will have to be made about priorities.

It is acknowledged that changes are needed to the system in terms of management, accountability, planning, resource allocation, location of services, contracts with health providers, regulation of the private sector, and financing. These are clearly identified in the government-accepted Health Sector Reform Proposal published in March 2000. Implementation of the reforms needs to be accelerated in order to prepare for a move to a universal health insurance scheme as a new financing system. Translating the health reform document into practice has been slow and erratic and is not being systematically managed. Should the lagging pace of reform in the delivery system implementation persist, the development of a universal health care coverage may fail.

Developments in primary health care are planned for the coming years and are being addressed separately, by the Ministry of Health. In 2003, the return to Saint Lucia of up to 30 newly qualified doctors provides a unique opportunity to develop and expand the role of family medicine and primary health care, in order to meet most of the clinical needs of a young population.

This report addresses the provision of secondary care, through a universal health insurance model. It outlines the current health situation, including the epidemiological picture, health financing and the system in general, the types of health care coverage currently available in Saint Lucia and its suitability for the development of a universal health insurance model.

Given the significant work which has already been undertaken in-country in relation to the health system, this report evaluates existing government plans for change in the health sector. Implementation of the Health Sector Reform Proposals, as agreed by the government in March 2000, is identified as an important precursor to developing universal health care coverage. The health reform proposals and the recent unpublished working papers of the current Government Special Task Force on health insurance are used as the basis for a workable, practical universal health insurance scheme inclusive of the whole population.

Conceptual issues which require executive decisions and political will are identified, including the potential for extension of coverage of the existing health insurance scheme, the incorporation of civil servants into a wider universal care scheme to create a larger risk pool, a proposed redefinition of the role of the Ministry of Health, and legal issues. Financing considerations are addressed in terms of the current expenditure on health and the project costs of a universal health care scheme, with options on how to accrue additional resources into the system while maintaining the principle of solidarity. The report addresses the technical application of the capitation method, especially in the initial stage of implementation of the universal health insurance system where there is limited reference data to rely upon for accurate calculations. The objectives of controlling the cost of health services and ensuring uniform rates apply to uniform services are looked into.

Prerequisites – critical success factors – for implementing a universal coverage scheme are specified, emphasizing the need for parallel implementation of the health system reform proposals, particularly the development of a proactive information and management culture, the establishment of clinical and buildings standards, licensing and continuing professional development for doctors, and a comprehensive

communications strategy. The importance of managing peoples' expectations of a universal coverage scheme cannot be overstated – this applies both to users and providers of health services.

A proposed timetable is presented for successful implementation of a universal health insurance scheme: it is indicative but not exhaustive. Many unanticipated issues will arise during the course of planning and implementation. Progress will be aided or thwarted by the parallel success or failure to implement the health system reform proposals. A recommended action plan is presented, including establishment of the Working Group necessary to kick-start the planning and implementation process. Exposure to other schemes and to training and development will be needed. One advantage is that Saint Lucia has already developed a knowledge base over the past few years in the work undertaken for the health reform proposals, which can shorten the time-scale countries usually need for the planning and implementation process.

Essential characteristics for the universal health insurance scheme are outlined on the following page. The ILO is keen to be associated with this health reform initiative, not least because the programme extends health care coverage on a universal basis to both the formally and informally employed. Including workers in the informal economy will provide an opportunity to create real solidarity, whereby all earners would contribute to the scheme, thus subsidizing those who are too young, too old or unable to work. In terms of financial revenue, this option (even if less than perfect) forces the expanding informal economy to face social security and health contributions and has major advantages from the perspective of long-term governance.

It is recognized that workability entails ongoing government commitment to health care, irrespective of other financial challenges in the budget, and that the mobilization of additional resources of health expenditure will be necessary. As the economic development programme progresses, this will form the background against which the health reform programme and universal health insurance are designed and implemented in Saint Lucia.

Table 1. Key characteristics for a recommended universal health insurance scheme in Saint Lucia

Issues	Description
Coverage	Total population
Contributors	All those who are working in the formal economy, including civil servants, those currently eligible to contribute to the National Insurance Corporation (NIC) scheme, and those who are working in the informal economy. Solidarity and social responsibility are the bases for development of the universal health insurance scheme.
Services to be provided	(a) All clinically necessary secondary care services, with exclusions to be defined by the Technical committee on medical issues. (b) Clinically necessary services which are not available in-country but which the scheme would purchase through an (NIC) accredited provider overseas. Eligibility for accessing treatment overseas would depend on authorization from NIC to the receiving provider, along with a letter of authorization from the Technical committee on medical issues, and the patient's medical records. The NIC would not accept responsibility to pay for any services accessed overseas by members without the necessary pre-authorization. Patients who are provided services overseas would not have individual choice of provider: contracts will be determined between the NIC and overseas providers, depending on clinical capacity, value for money, quality of service, and accessibility. (c) Exclusions from the package of benefits would include, inter alia, cosmetic surgery which is not clinically necessary, transplant surgery, open heart or brain surgery. Subject to the careful review of selection criteria for inclusions and exclusions of medical services, exclusions may need to be reviewed as the number of contributors to the scheme grows, as the scheme's financial base is made secure, and as services become available or their development is clinically necessary for the population.
Identification of beneficiaries	A unique personal identifier provided by the NIC will be issued to each beneficiary.
Management of the scheme	A newly established department within NIC, with a Technical committee on medical issues accountable to a Management Board.
Contracting for services	(a) Contracts will be agreed between the health insurance organization and the providers. Patients will register, through the NIC, with their preferred provider, which they can change after one year. Providers will be contracted to provide all clinically necessary services to each registered patient. Providers cannot exclude either high-risk patients or those with a pre-existing condition from registering. Contracts will incorporate clinical and buildings standards required to be met by providers (b) Contracts (block contracts) will be developed with accredited overseas providers for services not available in Saint Lucia, but which are deemed to be clinically necessary by the Technical committee on medical issues. Objective criteria to be established.
Paying providers	(a) Providers will be paid on a capitation basis for each registered patient, payable on a monthly basis (one-twelfth of the annual capitation rate). Weights may be developed for the capitation rate, where there is a high preponderance of very young or very old, or where there is a high incidence of chronic illness or disease. Weights will be determined over time, depending on the availability of accurate and reliable utilization data from providers, and on data available through census and epidemiological sources (b) Overseas providers will be paid either on a block-contract basis for illnesses and diseases which can be anticipated, and on a case-by-case basis for others.
Drugs and medicines	All drugs and medicines prescribed for secondary care inpatients and outpatients will be provided as part of the contract between NIC and the providers, through the capitation payment. Approved drugs and medicines will comprise the essential drug list as agreed by the Pharmaceutical Association and adopted by the Technical committee on medical issues of the health insurance organization. Where a patient prefers to use a brand-name drug instead of an appropriate generic drug, the patient assumes these costs directly. *Note: It is noted that this recommendation from the ILO differs from the preferred option of the Government Special Task Force.*
Providers of services	For provision of secondary care under the health insurance scheme, all secondary care hospitals will be eligible to become providers. Being accepted as a provider will depend on meeting the standards set by the health insurance organization. All accredited providers will be paid on exactly the same basis of capitation. Due account of the specific profile of a particular provider offering limited services may be required.

1. Analysing the current situation

1.1. Health sector

1.1.1. Recent health situation

The total population of Saint Lucia is 157,600 persons, with almost 10 per cent aged 60 and over. According to 1999 statistics, the population is growing at an estimated annual rate of 1.4 per cent, partly explained by a total fertility rate of 2.3 (above replacement level) and an increasing life expectancy of 68.9 years for men and 74.9 for women. [1] Dependency ratios have decreased over recent years to about 58 dependents per 100 persons in the labour force.

The Saint Lucian economy has gradually shifted its orientation from agriculture towards the tourism service sector. It is grouped by the World Bank as belonging to the middle-income countries (lower end) as its GDP *per capita* has steadily increased over time to reach almost US$ 4,000 today. Unemployment is relatively high at 18.9 per cent according to the 2001 Census. These factors bear an impact on the level of health in the population.

According to the WHO indicator of health attainment of 2000, Saint Lucia ranks 54 in the overall classification, close to Barbados and Trinidad and Tobago.

Economic growth has been very variable and is heavily dependent on tourism and, to a lesser degree, agriculture. The health status of a population bears a direct relationship to the potential for economic development and growth. The recent publication from the WHO-sponsored Commission on Macroeconomics and Health reports a direct correlation between investment in health and economic growth. [2] There is no challenge to this assertion in Saint Lucia: the challenge is in finding fair and equitable ways of financing health care to ensure a continuing improvement in health status for the population.

Improvement in health status is not achieved exclusively through the diagnosis and treatment of illnesses and diseases, although that is the most expensive part of a government's health care programme, but also through health education to secure healthy lifestyles, health promotion and illness prevention activities.

The Government of Saint Lucia is committed to maintaining its current level of financial commitment to health care, irrespective of other financial challenges in the budget. As indicated in section 1.1.3, the overall level of health expenditure is presently relatively low. The mobilization of additional resources for health care is needed and it is essential that the Government maintains its commitment to health care. As the economic development programme progresses this will form the background against which the health reform programme and universal health insurance (UHI) are designed and implemented.

1.1.2. Present health system

Two main pieces of legislation concern the health sector, the Public Hospitals Act of 1973, dealing mainly with administration provisions, and the Public Health Act of 1975.

The public health sector in Saint Lucia is mainly responsible for the organization and delivery of health care in the country. It operates (as a branch of the public service) under the Ministry of Health that allocates budgetary resources to the various components of the public health system. The main health

[1] Cf. Annex Table 2 of *World Health Report 2000*, WHO, Geneva.
[2] Macroeconomics and Health: Report of the Commission, WHO, Geneva, 2002.

programmes include preventive services, health education and promotion, environmental health, hospital and curative services.

Access to private health care is reasonably straightforward. Physicians who have attained consultant level are entitled to operate in the private sector. A number of well-trained and qualified physicians have returned to Saint Lucia post-training and there is a reasonable cadre of appropriate specialists on the island. Their frustration with equipment which is either not properly maintained or is outdated encourages doctors interested in clinical developments to purchase equipment from their own pockets and to provide private consultations and services at a location other than the public hospital. Clearly, such services are available to those who either choose to pay directly for care or who have private insurance and can reclaim the majority of the charge from the insurer. Some clinicians work out of private offices, while others have joined forces for private sector work to develop the private hospital. Almost all of the doctors working in the private sector also work in the public sector.

There are obvious barriers and limits to overall access to care, mainly on grounds of affordability. Most of the population is not protected by any form of health insurance and cannot afford more costly services in the private sector.

Regulation of private practice (in reality a regulation of public sector contracts) is poor and needs to be tightened – for the benefit of both the patients and individual doctors.

The health infrastructure in Saint Lucia relies on five hospitals providing public health care of which two are general hospitals. The Victoria Hospital in Castries is the main and largest public sector hospital; the St Jude Hospital in Vieux Fort provides mainly secondary care.

Saint Lucia has recently been awarded a grant from the European Commission to build a new secondary care hospital. The new hospital will replace the existing Victoria Hospital. Additionally, the Chinese Government has agreed to fund and build a new mental health hospital. While there appears to be some justification for the mental health hospital – though all expertise would normally advise integrating mental health services with other secondary care – the justification for the new secondary care hospital is not so clear.

Current utilization of Victoria Hospital is rarely above 50 per cent, suggesting that the number of beds is already too high for the level of utilization. Such a low utilization rate often also reflects a very low threshold of admission: there is no pressure on the beds and therefore patients are admitted when their symptoms do not warrant a hospital admission.

Management practice – including nurse management, clinical management, management of finances and management of supplies and consumables – is not coordinated at the hospital level. Current practices of the Victoria Hospital would need to be reviewed before importing them into a newly built hospital. Otherwise a new facility may do little to improve efficiency or effectiveness or to raise the current standards of care provided.

In tandem with the building of a new environment there should be a concerted management development programme for all staff, which would equip them to meet the changing needs of the health service sector in Saint Lucia.

There appears to be a growing lack of public confidence in the health services currently available. This is demonstrated by the growing number of people (who can afford it) choosing to access their elective health care outside the country. In many instances the health care they are accessing is available in the public health sector in Saint Lucia. In other instances, care is only available in the private health sector. Those who can afford to do so are still choosing to access care abroad.

The Ministry of Health presented a document in March 2000 on *Health Sector Reform Proposals*. Issues related to the health sector reform are addressed in Part 3 of the present report.

1.1.3. Health expenditure

Most of the health expenditure in Saint Lucia comes from public sources. In 1997, 65.1 per cent of health expenditure was paid from the Government's health consolidated fund. Private health expenditure represented about one-third of total health expenditure, most of which were out-of-pocket expenses.

The total health budget of Saint Lucia was estimated at US$ 20.2 million in 2000, representing an increase in nominal terms from previous years but a decrease as a percentage of the national budget. Table 1.1 shows fluctuations in the amount allocated to health over the past decade. On a *per capita* basis, health allocations have decreased, especially if taking inflation into account.

It should be noted that an annual direct contribution to the Ministry of Health (MOH) is paid by the National Insurance Corporation of Saint Lucia (NIC) in the amount of EC$ 3 million[3]. Key health expenditure figures for selected years are presented in Table 1.1.

Table 1.1. Fluctuations in health allocations and health expenditure figures, Saint Lucia health budget for 1991, 1995 and 2000

Item	Unit	1991	1995	2000
Saint Lucia Health budget	USD	21.4	18.9	20.2
	% of GDP	5.1	4.1	4.7
Per capita health budget	USD	157	130	130

Source: Ministry of Health (2002): *Annual Report of Chief Medical Officer 2000*, Saint Lucia.

Secondary care accounted for 63 per cent of health expenditure in 2000, a sharp increase from 46 per cent in 1998. Primary care services and tertiary care services accounted for 21 per cent and 6 per cent of total health expenditure respectively. Health administration at the central level accounted for 10 per cent of the total. In terms of functions, most health expenditure went towards curative care over recent years, for example, 45 per cent of the total in 2000. Preventive care and health promotion represented 19 per cent and facilities-related expenditure represented 13 per cent.

Estimates of the health accounts for Saint Lucia in 1997, as published in the WHO *World Health Report* 2000, indicate that 4.1 per cent of GDP accounts for health expenditure. Table 1.2 shows that the current level of public health expenditure appears in some cases substantially lower than observed in other countries of the region, as well as in other selected countries. In Saint Lucia, 8.0 per cent of total public expenditure was allocated to health.

Although there has been a firm commitment by the government towards maintaining its health expenditure levels, the overall level of expenditure will likely require increments in future to support the introduction of comprehensive health sector reforms and improvements in the health care delivery system.

[3] This text refers to the XCD (East Caribbean dollar) as EC$ throughout. At current rates of exchange, US$ 1 = XCD 2.70.

Table 1.2. Health expenditure data for Saint Lucia and selected countries, 1997 (US$)

	Total health expenditure as % of GDP	Breakdown of total health expenditure by source		Public health expenditure as % of all public expenditure	*Per capita* health expenditure (US$)
		Public	Private		
Saint Lucia	**4.1**	**65.1**	**34.9**	**8.0**	**211**
Caribbean region					
Barbados	7.3	62.5	37.5	13.7	596
Dominica	6.0	65.0	35.0	10.3	282
Jamaica	6.0	56.5	43.5	8.9	149
St Kitts and Nevis	6.0	51.5	48.5	10.4	404
St Vincent and Grenadines	5.9	66.5	31.4	9.5	211
Trinidad and Tobago	4.3	58.6	41.4	8.8	197
North and South American regions and the United Kingdom					
Canada	8.6	72.0	28.0	15.3	1783
Columbia	9.3	54.5	45.6	17.2	247
Costa Rica	8.7	77.1	23.0	20.1	226
Mexico	5.6	41.0	59.1	6.0	240
Panama	7.5	74.0	26.0	20.7	238
USA	13.7	44.1	55.9	18.5	4187
UK	5.8	96.9	3.1	14.3	1303

Sources: Ministry of Health of Saint Lucia (2002): *Annual Report of Chief Medical Officer*, 2000; WHO *World Health Report 2000*, Annex Table 8.

1.1.4. Health financing

The public health sector in Saint Lucia has been financed so far mainly through public funds. Table 1.3 shows the four major financing sources. Under its policy approach to universal health care coverage the government also continues to envisage a role for private insurance – largely as a financier of top-up benefits complementing the care financed by public systems – for all those who can afford that level of protection.

Table 1.3. Financing sources of the public health sector, as a percentage of total financing, 1993 to 2000

	1993	1994	1995	1996	1997	1998	1999	2000
Public sources:								
Health consolidated fund (Treasury)	80	83	79	85	84	83	85	79
MOH funds	7.6	8.8	7.3	7.8	7.5	7.5	6.9	6.5
NIC contribution	6.2	6.8	5.9	6.2	5.8	6.0	6.0	5.5
External sources:								
Grants [1] (capital projects)	6.4	1.6	8.3	1.0	2.4	3.4	2.0	9.2

[1] In 1993 and 1998, the grant amounts include 30 per cent and 19 per cent in loans respectively.
Source: Ministry of Health of Saint Lucia (2002): *Annual Report of Chief Medical Officer*, 2000.

1.2. Health insurance environment

1.2.1. Existing health insurance coverage for NIC insured persons and civil servants

Presently no nationwide system of universal health insurance exists in Saint Lucia. However, the environment for universal health insurance is favourable as the country has a long-established tradition of social security, established through the social insurance benefits provided by the NIC. The Government Special Task Force with whom this project is collaborating is active in designing a sound universal health insurance system. Universal health insurance plans were first addressed in a government report in 1996. [4]

The NIC provides a comprehensive set of benefits to employed persons, self-employed workers and voluntary contributors including:

- long-term benefits such as old-age pensions, invalidity pensions, survivorship pensions and grants;
- short-term benefits including sickness cash benefits, maternity allowances and grants, funeral grants and hospitalization and medical benefits; and
- employment injury benefits such as pensions, short-term cash benefits, medical expenses, survivor pensions and death grants.

Currently 42,000 people actively participate in the NIC scheme. [5]

The NIC therefore provides some health care financing. This is done through the NIC remitting the agreed upon lump-sum amounts to the MOH (equivalent to EC$ 3 million in 2000), to cover in principle inpatient hospital expenses incurred by NIC actively insured persons. It is not clear to what extent this amount meets the actual expenses incurred by NIC contributors.

The NIC provisions also stipulate that voluntary contributors are entitled to receive coverage for hospitalization and medical benefits. The contribution rate is set at 10 per cent of insurable earnings up to a ceiling on monthly earnings of EC$ 5,000. This implies in principle that anyone whose monthly contributions can amount up to EC$ 500 could receive health insurance through NIC voluntary coverage, depending on the declared earnings level of the voluntary insured person.

This is an important basis upon which further extension of health cover can be developed.

Civil servants also enjoy social security coverage under a scheme specifically designed for them that includes health insurance coverage. Many civil servants and their families enjoy private group health insurance coverage. Ideally, efforts should be undertaken to harmonize all social security provisions in the country. The provisions of health insurance to employed workers and civil servants should be unified and eventually brought under the umbrella of the universal health insurance system when it becomes operational.

1.2.2. Private health insurance

Private health insurance and private out-of-pocket payments for health services are features of the health system in Saint Lucia. Private insurance companies estimate that up to 12,000 people are covered by private health insurance. This coverage is mainly provided by group insurance contracts financed by

[4] Part 2 of the present report provides more information on the national health insurance developments.
[5] Actively insured members refer to contributors only. Inactive NIC insured persons may remain registered with NIC but are not entitled to health coverage unless their contributions are paid.

employers. The vast majority of hotel service workers, for example, have private health insurance as part of their terms and conditions of services, negotiated on their behalf through trade unions.

Other industries, enterprises and companies have negotiated private insurance for their workers – with different levels of health cover depending on the seniority of the worker. The liability limit of most private health insurance is EC$ 250,000, with some policies offering up to EC$ 500,000 liability. Pre-existing conditions are excluded from cover. A person who changes jobs is medically reassessed before being accepted into a new private health policy. There is generally no post-retirement cover. This leaves significant gaps in the country's present health insurance coverage. At the same time the overall financing system could feature important inconsistencies, as the coverage of the different financing arrangements is not clearly defined. For example, private insurance might cover workers who should theoretically be also covered by the health care cost cover provided through the NIC lump-sum that is paid to the Victoria Hospital.

Post-retirement health insurance coverage remains an issue in Saint Lucia which should be within the focus of the universal health care system.

As in some other small countries with a small risk pool, private health insurance is not a profitable operation. Almost all of the private insurers include life cover as an integral part of the overall insurance cover negotiated at employer level (life cover being more profitable). Private insurers in Saint Lucia pay out usually up to 80 per cent of charges to patients, with the patient bearing the remaining 20 per cent. Private insurance coverage relates essentially to curative care as small amounts go towards health promotion, prevention or education. That role will also in future have to be assumed more strongly by the government as it reduces the overall cost of the universal health care system in the medium to long term.

The MOH has no jurisdiction over private health insurance arrangements, notably to regulate the calculation of acceptable health insurance premiums, benefit packages, or fee schedules. It thus misses important tools in the overall governance of the health sector. This is by no means a trivial deficiency in the governance of the health sector. The pattern of private practice is to a large extent shaped by the benefit and provider payment provisions in private insurance contracts. As most practitioners are operating both in the public and private sectors, their behaviour, income expectations and the time they allocate to public services are influenced by their private sector activities. This underlines the central responsibility of the government for setting the "rules" of the market under any health care financing system.

1.3. Justification for universal health insurance

Access to health care is limited and unequal in Saint Lucia mainly due to monetary barriers. Quality of care differs between the public and the private sector and in both sectors fees and charges are prohibitive for many people. Most of the population is not protected by any form of health insurance. There is therefore a need to improve both access to and the quality of health care for those groups not covered by either the NIC arrangements or the civil servants' scheme. Providing universal access is the overriding justification to introduce universal health insurance in Saint Lucia.

The public health care delivery system has a comprehensive organization that – with sufficient financing – should have the necessary elements to meet the expectations of the population in terms of access and quality of care. It relies on a well-organized set of programmes and administration. The social security environment in Saint Lucia is also favourable to the introduction of universal health insurance. The NIC is operating successfully and is built on good governance principles. Its provisions for voluntary coverage already foresee the possibility to extend the coverage of hospitalization and medical expenses to larger numbers of the population. Also, efforts are being made to extend NIC mandatory coverage for long-term benefits, short-term benefits and employment injury benefits to all workers, notably farmers.

Private insurance is not a valid option to provide health insurance to significant numbers of the population. Most individuals seem unable to afford income-independent private insurance premiums. The

risks excluded in typical insurance contracts, determined under strict private insurance principles, mean that people cannot get protection when they would most need it.

Interviews conducted in the communities at the initiative of the Health Sector Reform Secretariat indicated that "health users were willing to pay for health care if these services were improved" on a prepaid basis but objected to a "cash on delivery of service" approach. They preferred pre-payment, insurance or taxation, or a billing system as financing options to the present system.[6] It was also highlighted that coverage of dependent family members would be sought by most working-age persons potentially covered by a universal health insurance system. There is also an obvious need to provide health care free of charge to people who have no means either to meet its cost or any form of health contributions/premiums. A universal health insurance system is likely to provide the best answer to the needs expressed by the population.

It has been observed that more emphasis may have been placed on the development of health facilities in urban areas in recent years despite access to health services in rural areas. It is usual to find in most countries that the rural population has relatively limited physical access to health care. Universal health insurance alone may not tackle the deficiencies of physical access to the services of the health care delivery system. In principle, however, it would make health care available to the rural population, provided they travel to those areas where health services are available.

Saint Lucia is a middle-income country whose population expects better standards of living and thus better quality health coverage. Health care is a basic need that should be affordable. Total public health expenditure in Saint Lucia account is relatively low by international standards and by comparison with other countries in the region. Health insurance will inject additional resources into the sector but, in exchange, insured persons will demand or expect better services. These additional resources are thus not likely to create savings for the government. The coverage of those who cannot afford to contribute will require subsidies. For this reason and in order to generally meet increasing expectations in the population, the present relatively low share of the public budget allocated to health care will most likely have to increase – even in the context of a new universal health insurance system.

Universal health insurance is thus not a source of additional funds to meet government obligations. It is a means to better meet the health care needs of the population by increasing the overall national resources available for health care. It is a timely complement to the health sector reform programme that is already under way. The political will exists to sustain the efforts needed to introduce universal health insurance which, in turn, necessitates integrating different levels of the public administration in Saint Lucia.

Efforts were made in 1996 to introduce a National Health Insurance Act but its actual implementation has been delayed, leading to new demands to introduce a universal system.

Part 2 depicts the history of government reform plans. It also explores their core objectives in relation to the ILO proposals for universal health insurance in Saint Lucia.

[6] Cf. MOH (2002): *Health Sector Reform Proposals*, p. 25.

2. The history of health reform plans and the ILO proposal

2.1. Historical perspective

The commitment of the government of Saint Lucia to the establishment of universal health insurance dates back to 1996 when a bill was passed by Parliament allowing for the establishment of a social health insurance scheme. The bill has never been implemented or enforced and is inherently flawed in its drafting. Review of the legislation reveals a significant number of inaccuracies, contradictions and ambiguities, for example in relation to coverage, contributions, entitlement to care, and beneficiaries.

The National Insurance Corporation Act No. 18 of 2000 mandates the National Insurance Corporation to provide for social security contingencies for workers and, sometimes, for the families of workers. Health care is perceived as one of the potential developments within the scheme.

The National Health Reform Programme issued in 2000 reflected growing concern about the inability of the health system to meet the needs of the population in terms of resources (both financial and human), access to appropriate health services, management capacity and planning capacity. The National Health Reform Programme was adopted and agreed by government but its implementation has been slow and intermittent. The programme is ambitious but is a necessary development if Saint Lucia is to improve and maintain health at a level which encourages full participation in the economic growth and development of the country.

The capacity to galvanize the system and the skills required to manage change in a holistic way are presently not available in Saint Lucia. One of the aspects included in the health reform programme is the need to develop a social insurance scheme which would provide health care to the population of Saint Lucia. While other aspects of the health reform programme have been left to the Ministry of Health to effect and implement (without significant external support) this particular aspect of the reform document has been identified as a key issue for government.

A Concept Note produced in advance of the ILO mission by the Government Special Task Force Subcommittee on health insurance identifies a number of principles on which proposals for health care coverage should be based. The Concept Note is not government policy: it is the paper being used by the Health Insurance Subcommittee to develop the ideas and vision for social health insurance. The Concept Note provided a very useful basis for discussion and debate in the early part of the ILO mission, to determine the areas of agreement and the specific principles which are crucial to the development of any health insurance scheme. The Concept Note was written in the context of a universal acceptance of the principles of equity, efficient and effectiveness. It also included a number of principles which were accepted by the Subcommittee as desirable for a social insurance scheme. These are:

- *universality*: everyone should have access to appropriate levels of care and service;
- *solidarity* through risk pooling (healthy, sick, wealthy, poorer, young and old);
- *equity*: everyone should have the same guaranteed package of basic health services, which does not preclude people (those who want to and can afford to) from purchasing private, individual-risk based health insurance as well; and
- *cost-effectiveness*: providing appropriate services to a specified standard and within defined cost constraints.

Each of these principles accommodates the internationally accepted basis of health insurance.

The Concept Note indicated that three core objectives needed to be addressed in designing a universal health care coverage scheme. These are:

- revenue generation;
- risk pooling and fund management; and
- strategic purchasing.

The ILO position is that revenue generation should not be a core objective for introducing a universal health insurance scheme. Certainly the scheme will need to be designed on a sound financial basis but core objectives should relate to the provision of universal and equitable access to appropriate health services. This is the main justification for introducing universal health insurance.

A number of proposals for the organization of the scheme are made in the Concept Note, all of which were discussed with key players and stakeholders during the course of the ILO visit (and separately in discussions between Task Force members and stakeholders).

The document puts forward some suggestions on the desirability of including the whole population as beneficiaries of the scheme, on risk pooling, on possible new sources of financing for the scheme and on the division between purchaser and provider roles in health services. These issues were discussed in detail with the Government Special Task Force and key players during the course of the ILO visit, in addition to the feasibility of alternative ideas using other international experiences. Since the Concept Note was produced as an internal working paper for the Task Force, its contents are not minutely analysed in this paper. Boxes 2.1, 2.2 and 2.3 highlight the three core objectives of the Concept Note. The Task Force plans to take account of the detailed discussions and make further refinements when developing its official report to the government

Box 2.1. Some comments on the core objectives as outlined in the Concept Note of the Government Special Task Force

Objective 1. Revenue generation[1]

Government has agreed to continue to contribute to health sector financing under a new universal health care system to the same extent as at present. The collection of resources to fund the universal health insurance system will be based on social responsibility principles and the concept of solidarity and risk pooling – the basis for any social insurance scheme. All citizens would be entitled to access health services and all would ultimately have a responsibility to contribute, where they are able, subject to additional financing through general tax revenues.

Possible sources of financing for the new universal health insurance system as proposed by the Government Special Task Force include:

- levy on electricity
- telephone charges
- specific consumption taxes
- levy on imports
- licensing fees
- salary contributions (at a later stage only); and
- value-added tax (at a later stage only).

According to the Concept Note, the required total annual budget for public health care under the proposed universal health insurance system would amount to EC$ 61 million. The actual total health budget amounts to only EC$ 52 million, of which EC$ 45 million comes from the government's budget allocated to the health consolidated fund. According to the latest experience figures of a study by the Pan-American Health Organization, there is thus an estimated resource gap of EC$ 9 million.

According to the Government Special Task Force, the proposed health expenditure to be financed by new sources of financing under the universal health insurance system amounts to EC$ 16 million – in addition to the continued allocation equivalent to EC$ 45 million made by the Government – corresponding to:

(a) the need to increase fees (EC$ 4 million)

plus

(b) the replacement of NIC-related health expenditure (EC$ 3 million)[2]

plus

(c) the resource gap (estimated at EC$ 9 million)

Government thus intends to diversify the revenue collection as much as possible to minimize the negative impacts of economic downturns. This concern is not clearly addressed. None of the proposed sources of health financing ensures that revenues will be maintained during difficult economic times – when health expenditure usually tends to increase and revenues to decrease. The maintenance of a special contingency fund under the universal care system would counter such circumstances in economic downturns.

In addition, the selection of financing sources should be based on their potential stability, to ensure that universal health insurance system will not run into regular budgetary shortfalls requiring major amendments in the way universal health insurance is financed. An in-depth study of the past stability of these financing sources in line with policies for the future is also needed.

The government proposal states that the same contribution from public funds, equivalent to EC$ 45 million in 2000, would continue to be provided towards the public health sector, either expressed as a constant percentage allocation of the total government budget (7.5 per cent) or as a constant percentage allocation of gross domestic product (4.7 per cent). This financing contribution is not explicitly linked to the development of health utilization expenditure data, i.e. expressed in terms of utilization rates, costs per unit care, and resulting cost for different services covered by universal health insurance. It is advisable that government's overall commitment to health care financing and its exact nature be explicitly acknowledged in the legislation. Its level should be publicly discussed, to ensure that it represents a democratically chosen priority for public spending. As Part 1 mentioned, the overall present level of public spending on health in Saint Lucia is relatively low in comparison to other countries of the region. This should be acknowledged when defining the level of financing coming from general revenues under the new universal health insurance system. Officials in charge of public health budgeting should agree with health planners on the projection of expected costs and determine if an overall budget allocation to the universal health insurance system – as a percentage of GDP or as a percentage of the total public budget – is reliable and sufficiently stable to face the demand for services in various scenarios under the proposed universal health insurance system.

Notes

[1] Part 4 of the present report examines the financing of a universal health insurance system.

[2] Assumed equal to the current NIC transfer to MOH to cover inpatient expenses on behalf of NIC insured persons.

Box 2.2. Some comments on the core objectives as outlined in the Concept Note of the Government Special Task Force

Objective 2. Risk pooling and fund management

The basic premise of this analysis is that there will be universal coverage whereby access to all health services comprised in the essential package is guaranteed. This rules out other optional forms of more limited coverage for health insurance (for example, providing coverage only to salaried workers who can contribute). The scheme will therefore include all 157,600 of the population irrespective of health status or their ability to contribute to the scheme. This is the most comprehensive form of health insurance coverage that exists. The International Labour Conference of 2001 supported as a matter of priority the development of universal social security systems as a meaningful way to provide sustainable social protection and to alleviate poverty.

Universal health insurance cannot be developed and implemented in a vacuum. Many issues impact on the potential success of such a scheme, both inside and outside the health sector. The development of universal health insurance is not – and should not be – merely a way of augmenting resources in the current health system. It is a change in the way services are provided and in the way resources are spent on behalf of members of the scheme.

The population of Saint Lucia is 157,600, with nearly 70 per cent of people under 40 years of age.[1] Universal health insurance is based on two essential conditions:

- contributions from all those who can afford to contribute, with the young subsidizing the elderly, the wealthier subsidizing the poorer, the healthy subsidizing the sick; this condition may need to be gradually implemented in view of the administrative constraints usually faced when developing a system to be fully relying on salary-based contributions and when the size of the informal economy is still significant;
- accepting everyone into the risk pool: unlike private insurance, no-one is excluded because of a pre-existing medical or clinical condition.

Universal coverage can be a confusing term. In Saint Lucia (as in many other small countries faced with similar challenges) the term needs to be more explicitly defined, to reduce confusion and to limit expectations to a realistic level. While everyone would be entitled to health care under the universal health insurance system, the range of health care available has to be limited. The type of care available has to be provided within the following constraints:

- the financial capacity of Saint Lucia's small economy;
- the technical capacity of the clinical staff in the health sector; and
- the feasibility of providing all clinical specialties in an environment where the demand does not warrant the associated development and operational costs.

Balancing all these factors presents a serious challenge.

Very clear definitions that are verifiable need to be adopted and implemented. Section 3.1 of the present report provides additional comments on the issue of coverage definition of the new universal health insurance system and on corresponding legislative considerations. The definition of qualified residents should relate to the Income Tax Act No. 1 of 1989.

In terms of proposed developments for social insurance (notably the proposed expansion of the scheme to include informal workers) and in terms of the expressed goals for universal health insurance to be equitable and fair, the concept of solidarity as stipulated in the social insurance legislation provides an appropriate basis for inclusion of health as a benefit.

The government proposal intends to delegate the administrative functions of the new universal health insurance system to the NIC. Registration, revenue collection, providers' payments, information management and monitoring functions would all fall under the NIC. This appears to be the most logical option for administration: the start-up costs and maintenance expenses of setting up a new administration for initiating the universal health insurance system would be lessened and, overall, there would be a rationalization of administrative expenses for social security. In addition, the extension of other social security benefits (pensions, for example) to the entire population of Saint Lucia would be made easier if all the population is registered with the universal health insurance system through the NIC.

The government proposal states that the governing body of the new administration in charge of universal health insurance would include representatives from the finance sector, health providers (public and private), from the enterprise sector, from the private insurance sector and the NIC. There should be representatives of the key insured population groups, notably representatives of workers and key community groups, including those involved in the delivery of community health services (promotion) and other forms of social welfare.

Note

[1] Ministry of Finance (2001): *Saint Lucia Economic and Social Review 2001*, International Financial Services and Economic Affairs, Saint Lucia.

Box 2.3. Some comments on the core objectives as outlined in the Concept Note of the Government Special Task Force

Objective 3. Strategic purchasing

The specific health care services covered by the proposed universal health insurance system would include:

- inpatient services;
- emergency services;
- essential drugs; and
- overseas health care for selected services.

The specific health expenses that would need to continue being covered by the public health budget – i.e. the so-called health consolidated fund – would include all expenses related to:

- public health programmes;
- outpatient health care provided by health centres (community), polyclinics and district hospitals;
- public antenatal care;
- renal dialysis services; and
- an estimated 80 per cent of the operational budget of public hospitals.

The government proposal foresees that there would be two types of provider: the public and private sectors. Public sector providers would receive from the universal health insurance system a fixed amount covering the cost of a predetermined number of health services at a predetermined unit cost. Any incurred excess cost in the public sector would be covered by the government. Private sector health providers would be contracted (on a supplemental fee-for-service/per diem rate within an annual budget under the universal health insurance system) to provide the same health benefits as public health providers. Here, the ILO proposal is that fees in private hospitals should be calculated on the same basis as in public hospitals, possibly combined with some form of stop-loss insurance.

The government foresees that overseas health care would be contracted separately by the universal health insurance system. The estimated cost to universal health insurance would amount to EC$ 2.5 million.

2.2. ILO proposals for universal health insurance in Saint Lucia

It should be stated at the outset that many of the proposals made by the Government Special Task Force for the development and implementation of universal health insurance were sound. A number either were not feasible or would have been extremely difficult or expensive to implement successfully. The Task Force sought the ILO's international experience in these areas and used ILO expertise very effectively to analyse government goals and objectives and to determine practical, workable options to achieve them. This process was interactive: the template presented in Box 2.4 incorporates the views, expectations and concerns of the ILO and participants in discussions. It also incorporates and extends many of the proposals included in the Task Force Concept Note.

Box 2.4. Proposed template for a universal health care coverage in Saint Lucia

Issue	Description
Coverage	Total population
Contributors	All those who are working in the formal economy, including civil servants, those currently eligible to contribute to the NIC scheme, and those who are working in the informal economy. Solidarity and social responsibility are the bases for development of the universal health insurance scheme.
Services to be provided	(a) All clinically necessary secondary care services, with exclusions to be defined by the technical committee on medical issues. (b) Clinically necessary services which are not available in-country but which the scheme would purchase through an (NIC) accredited provider overseas. Eligibility for accessing treatment overseas would depend on authorization from NIC to the receiving provider, along with a letter of authorization from the technical committee on medical issues, and the patient's medical records. The NIC would not accept responsibility to pay for any services accessed overseas by members without the necessary pre-authorization. Patients who are provided services overseas would not have individual choice of provider: contracts will be determined between the NIC and overseas providers, depending on clinical capacity, value for money, quality of service, and accessibility. (c) Exclusions from the package of benefits would include, *inter alia*, cosmetic surgery which is not clinically necessary, transplant surgery, open heart or brain surgery. Subject to the careful review of selection criteria for inclusions and exclusions of medical services, exclusions may need to be reviewed as the number of contributors to the scheme grows, as the scheme's financial base is made secure, and as services become available or their development is clinically necessary for the population.
Identification of beneficiaries	A unique personal identifier provided by the NIC will be issued to each beneficiary.
Management of the scheme	A newly established department within NIC, with a Technical committee on medical issues accountable to a Management Board.
Contracting for services	(a) Contracts will be agreed between the health insurance organization and the providers. Patients will register, through the NIC, with their preferred provider, which they can change after one year. Providers will be contracted to provide all clinically necessary services to each registered patient. Providers cannot exclude either high-risk patients or those with a pre-existing condition from registering. Contracts will incorporate clinical and buildings standards required to be met by providers (b) Contracts (block contracts) will be developed with accredited overseas providers for services not available in Saint Lucia, but which are deemed to be clinically necessary by the Technical committee on medical issues. Objective criteria to be established.
Paying providers	(a) Providers will be paid on a capitation basis for each registered patient, payable on a monthly basis (one-twelfth of the annual capitation rate). Weights may be developed for the capitation rate, where there is a high preponderance of very young or very old, or where there is a high incidence of chronic illness or disease. Weights will be determined over time, depending on the availability of accurate and reliable utilization data from providers, and on data available through census and epidemiological sources (b) (b) Overseas providers will be paid either on a block-contract basis for illnesses and diseases which can be anticipated already, and on a case-by-case basis for others.
Drugs and medicines	All drugs and medicines prescribed for secondary care inpatients and outpatients will be provided as part of the contract between NIC and the providers, through the capitation payment. Approved drugs and medicines will comprise the essential drug list as agreed by the Pharmaceutical Association and adopted by the Technical committee on medical issues of the health insurance organization. Where a patient prefers to use a brand-name drug instead of an appropriate generic drug, this cost will be assumed directly by the patient. *Note: It is noted that this recommendation from the ILO differs from the preferred option of the Government Special Task Force.*
Providers of services	For provision of secondary care under the health insurance scheme, all secondary care hospitals will be eligible to become providers. Being accepted as a provider will depend on meeting the standards set by the health insurance organization. All accredited providers will be paid on exactly the same basis of capitation. Due account of the specific profile of a particular provider offering limited services may be required.

Practical issues which need to be addressed in the planning and development of a universal health insurance scheme and how to establish the appropriate environment to achieve the required preparatory work are dealt with in the following sections of this report. Part 3 offers some major strategic proposals on the road to successful implementation of universal health care coverage in Saint Lucia.

3. Conceptual issues prior to adopting universal health insurance

Here, the main issues comprise:

- a revised role for the Ministry of Health
- the development of the purchaser role on behalf of members
- development of an explicit relationship between primary and secondary health care.

Additionally, there are a number of critical success factors which, if not implemented or acted on, will undermine the success of the scheme.

The following sections tackle a series of conceptual issues that need priority attention for the design of the new universal health insurance system and propose the main strategies that would lead to its successful implementation.

3.1. Universal health insurance coverage considerations

3.1.1. Definition of coverage and potential contributors

It is important that the proposed health insurance system provides an effective and equitable coverage to the population of Saint Lucia. In principle, health care coverage can be provided on two bases:

An entitlement-related basis related to contributions:
Contributory health insurance is normally provided on a compulsory basis by collecting contributions as a percentage of insurable earnings for all workers engaged in formal gainful employment and their dependents. In Saint Lucia, such a definition of coverage would likely be limited to workers already covered by the NIC and civil servants. It would imply that the significant share of the population in the informal economy is not accessing social insurance – unless special measures are introduced to cover them as well, notably through the NIC. It has the advantage of having a clear financing source that is not prone to political manipulation.

A rights-based approach related to citizenship, residency and other criteria, such as age, if coverage has to be limited in view of available resources:
This is normally paid out of general taxation or other similar sources. It normally implies universal coverage. It is the most equitable and solidarity-based health protection and it provides an efficient tool to alleviate poverty for an entire society. This type of coverage makes sense as long as the health care provided from public revenues for the total population is in line with their needs and expectations. This may not always be the case and is one of the main dilemmas of universal health insurance systems whose sole source of financing comes from general revenues.

The Government Special Task Force has opted for the rights-based approach for the universal health care system to be set up.

In adopting a definition for the coverage of the universal health insurance system in Saint Lucia, policy makers should bear in mind the above principles of universal health insurance in light of the following factors:

- equity and solidarity concerns;
- the financing capacity of the State and how financial resources will be generated in future to cover health expenditure of the universal health insurance system;

- the size of and contributory capacity of the workforce employed in the formal economy; and
- the complexity of administering a coverage definition and its related cost to be borne by the State and/or the insured workers.

In Saint Lucia there is a small risk pool of potential contributors (all those who are working or earning – a total of only about 52,425 persons) to be balanced against an average health risk for a population total of 157,600. The population segments with an earning capacity as of 2002 comprise:

(a) present NIC actives: 32,920;

(b) present civil servants: 4,165; and

(c) other employed persons (informal economy): 15,340.

Groups (a) and (b) represent almost two-thirds of those already registered while administrative difficulty for registration (for contribution collection purposes) would mainly concern group (c) or less than one-third of the potential group of contributors to the universal health insurance system.

The registration basis – individual or family – on which the population is affiliated to the universal health insurance system will need to be determined.

The option for individual registration implies that a person would sign up with a selected hospital. Individual registration could be organized as described in section 3.4 of this report. This is the preferred option of the Government Special Task Force that also opts for the general tax base financing approach to ensure greater coverage and a more equitable form of contribution to the universal health care system.

If affiliation depends on advance registration and contribution payments, the family basis may be used: if the 52,425 potential contributors (mentioned above) have 1.5 dependents per person on average, this would imply that the registration of contributing families to universal health insurance could cover 131,060 persons out of a total potential covered population of 157,600 persons (82 per cent of the total population). [7] This would bring pressure to bear on developing a registration and contribution-collection mechanism that would apply to employed persons not currently covered by NIC or by the schemes for civil servants. Although this issue is beyond the scope of the present report and the subject of the ILO report on the extension of social security to farmers and fishers, Box 3.1 outlines some useful ideas. The challenge is in attempting to cover the remaining population, or between 18 and 49 per cent of the total targeted population, under the proposed universal health insurance system.

Many of the 15,340 persons employed in the informal economy as taken into account above are able to contribute to a universal health insurance system and to take social responsibility for their share of health care costs. The difficulty would be in complying them to register and in tracking those who do not. Similarly, civil servants with a salary base of EC$ 120 million are able to contribute to the social insurance scheme and so take on the social responsibility of solidarity. As mentioned earlier, many civil servants already contribute to a private health insurance scheme through their staff association and many may choose to continue with private insurance in addition to their universal health insurance contributions.

The solidarity issue is crucially important when looking at eligibility on a contributory basis. It is obvious that a proportion of the population would not be in a financial position to contribute. This is the group for which the government and, by extension, the universal health insurance fund would take

[7] These are rough estimates of the range of potential insured persons and insured dependents. It does not take account of possible double-counting as there may be families with two working insured contributors.

responsibility – either through a special welfare-type government allocation that would subsidize their contributions or by increasing the contributions otherwise payable to the UHI system.

Where registration to UHI would be adopted on a family basis, the challenge would be in getting those unaccounted for to register and to subsidize their implicit contributions to the UHI system. The latter would include mainly unemployed persons in the labour force and inactive persons outside of the labour force who are not dependents of any insured person. The proposed UHI system should foresee that the allocation to universal health insurance made by the government covers the entire health cost for these persons. On a strict capitation basis, it would be easy to determine such an amount: all registered insured persons and their families would pay a contribution equivalent to the unit capitation fee. A subsidy from the UHI special fund would be sought for all others who register but cannot pay the contribution/capitation.

It may be mentioned that voluntary health insurance is absolutely discouraged. This system would be prone to major adverse selection and other moral hazard problems which would most likely result in constant imbalances between expenditure and revenues (due to low revenues and high expenditure). Experiences shows that people tend to join a health insurance scheme voluntarily when they feel they will need health care and do not see the need for registering and contributing when they are healthy.

Box 3.1. Useful suggestions on how to achieve universal registration

For various types of performance measurement and control of the delivery and financing system all residents (as defined according to the Income Tax Act No. 1 of 1989) should be registered with the universal health insurance scheme and all economically actives should be subject to contributions. People whose income is too low to pay the contributions for themselves and their families should receive subsidies or exemptions.

Registration is easy to achieve for NIC members and civil servants. In a first wave or registration they would be issued with membership cards and asked to register all dependents. Similarly, non-contributors to the NIC would be requested to come forward and register themselves and their families. If they cannot pay they would have to claim for exemption of subsidies at the same time. If providers were to be paid on a capitation basis then they would also have to be allocated to the providers.

The non-registered part of the population would then be identified gradually when they resort to providers for care. If they do not possess a membership card the provider would not deny treatment but would report them to the scheme's administration, which would then request contribution payments or issue exemptions. Within a few years full registration should be achieved. It is expected that this mechanism would also gradually increase compliance in the social security system.

3.1.2. Alignment with the definition of coverage under the NIC

The definition of coverage under the proposed UHI system should be aligned with the definition of coverage under the NIC. This would require further refinements to existing definitions, notably in respect of dependents f the universal health insurance coverage is defined on a family basis. This should be introduced in the form of regulations. Assuming the NIC is mandated with the administration of the new UHI system, this alignment of coverage definitions is absolutely necessary.

In addition a uniform definition of covered persons and covered earnings is essential, so that employers who have to register and declare workers' earnings can do so in a streamlined manner. The role of employers should not be overlooked in designing the administrative apparatus of the new UHI system. They should be consulted in due course to take account of their constraints and to ensure their full collaboration.

3.1.3. Unification of the existing health insurance scheme covering civil servants with a prospective national scheme

From a social insurance perspective there is little to justify maintaining a separate social security scheme for civil servants: given the low population base, more financial stability could be achieved through merging schemes. Expansion of the social security scheme to include all civil servants (approximately 4,165 persons) should be considered as the next step to the recent inclusion of new civil

service recruits into the scheme as of January 2003. Their inclusion in the new UHI system would imply automatic coverage of their dependents if the family coverage definition is adopted.

3.1.4. Extending universal health insurance to the employed informal economy

Currently it is estimated that approximately 15,000-16,000 persons work in the informal economy in Saint Lucia. As previously mentioned, the informal economy is expanding rapidly, a pattern that economists predict will continue. Mechanisms need to be developed to include informal workers into Saint Lucia's social security scheme and its UHI system. Informal economy workers will also need pensions, maternity provision (health care and salary replacement) and protection against major financial contingencies relating to work and earning. All of the poor are in the informal sector but not all in the informal sector are poor. Those working in the informal economy do not participate in the NIC schemes and are thus excluded from (or opt out of) social responsibility or social solidarity. Incorporating informal economy workers into the health insurance scheme is a necessary forward step, particularly when UHI is implemented.

Various methods for covering informal economy workers have been put in place in other countries. Few have been observed to succeed because of a lack of methods to declare informal earnings, made especially difficult to achieve when general income taxation measures do not target them or are not effectively applied. If the definition of contributors under universal health insurance is not expanded to include those working in the informal economy, it will mean that those who are *not* contributing to the universal coverage scheme –but *are* earning – are cheating those who are contributing and shifting an unfair degree of social responsibility onto the shoulders of some. From a social insurance perspective, only those who are not actually earning should be entitled to subsidized benefits without having to pay contributions. In some cases subsidies will be unavoidable. The cost of their participation in the UHI system would be borne either implicitly by charging these costs to contributing members or explicitly through transfers from general revenues.

3.2. Issues related to universal health insurance benefit provisions

When contemplating a fairly radical change to how health care is provided and funded, it is essential to analyze the health needs of the population based on the epidemiological picture. In Saint Lucia this picture is available for mortality but there is no systematic way of collecting morbidity data for the population. The Victoria Hospital has an admission summary sheet that, if completed clearly and fully by the discharging clinician, could provide good base data on which to code diagnoses and interventions.[8] The coding of the clinical data provides information that can be used to reflect the activity of the hospital as well as for a costing system, thus showing the volume of work being undertaken as well as its associated costs to the hospital. Without morbidity data, it is difficult to anticipate costs or to defend requests for increased resources. Even if the discharge summary system were working effectively in Victoria Hospital it would only provide part of the country's epidemiological picture. In order to identify priorities, all hospitals providing secondary care should be collecting this base data, to reflect the overall health needs and, indeed, to track changes in and improvements to the health status of the population.

In an ideal world every possible service – with clinicians, nursing, technical and support staff all trained and ready to provide those services – would be available and resources would be available to fund them. No country is in the happy position of living in this ideal world. Instead they all face the prospect of balancing the known health needs of the population with the clinical capacity to diagnose and treat them and the financial resources to meet the costs of that diagnosis and treatment.

There are sound and legitimate reasons why all health services should not be provided in Saint Lucia through the public health system. First, with such a small population there can be no clinical justification

[8] Using the internationally accepted International Classification of Diseases, Version 10 (ICD10).

for providing services with only a slight incidence. Without regular and ongoing involvement in the treatment of certain illnesses and diseases, clinical competence is inevitably reduced, also making it less safe for patients to be treated. Second, the provision of care, treatment and intervention for illnesses and diseases whose incidence is slight also has major implications for the availability and maintenance of equipment, the purchase of which would be hugely disproportionate to the resources spent on other illnesses with much higher incidence rates. Conversely, it is entirely appropriate to identify and explicitly specify which diagnoses, illnesses and diseases *will* be treated in the system, based on the incidence levels and clinical competencies available.

Clearly the need for clean, accepted clinical data reflecting the diagnoses and treatment of patients using secondary care is crucial for moving to the next stage. For that reason, the development of an integrated hospital information system is the first recommendation, in order to prepare for the introduction of a more cohesive and information-led service. The hospital information system should include data and information from laboratory, x-ray, supplies, pharmacy and finance and would facilitate more informed decision-making on the operation and management of hospitals and on future strategies for the development of services.

An important part of the balancing act of providing appropriate health care to the population is to ensure that the decisions are not based solely on available resources but on clinical need, clinical capacity, competence and availability. The development of straightforward clinical standards (starting with the most common diagnoses and diseases) is the first step to ensuring that the services provided are acceptable to clinicians, patients and managers alike. The development of these standards has to be an inclusive process, with active participation from all of the team providing care and services to the patient.

The proposed universal health insurance system should therefore rely on the definition of clear legal provisions on:

- a package of benefits and limits;
- an "essential drugs" list;
- treatments through overseas health care; and
- accidents and emergency services.

3.3. Issues related to universal health insurance structure and administration

3.3.1. Differentiated roles of MOH, NIC and other actors

It is crucial that a distinction is made between the roles of provider and purchaser of health services. It is obvious that these two roles should not be assumed by the same entity because of conflict of interest. While the health care provider wants to receive as much resource as possible to face the demand for health care; the purchaser wants to obtain the best price for health care with the limited available resources.

In this respect it is important that the introduction of a universal health insurance scheme should be based on revised structures. Inevitably, significant efforts should be made towards capacity-building to respond to the new requirements.

3.3.2. The role of the Ministry of Health in the health sector

According to the health sector reform proposals of the MOH formulated in 2000,[9] there is an expressed interest for the MOH to play the leading role in the allocation and monitoring of health system funds. This may not be possible under a universal health insurance system: there must be a clear differentiation between the roles of provider of health care, naturally assumed by the MOH in any country, and purchaser of health care, assumed by the universal health insurance administration. As mentioned above, combining these two functions would create an inevitable conflict of interest. The role of the MOH could be limited to:

- strategy and planning of health care
- primary care
- development of standards
- operating provider units
- database and epidemiological picture
- development of health services
- the regulatory environment.

The current role of the Ministry is diversified. Officers are responsible for the planning of health care, immunization and vaccination of children, provision of health care through primary care facilities and the public hospitals, regulating health provision, contracting with health providers, collection and analysis of mortality data, collection and analysis of health status data, and a wide range of other detailed and time-consuming issues. It would be more appropriate to focus the role of the Ministry on strategic and operational issues that are within their remit and for which the Ministry is best placed to provide service and advice. The Ministry role in strategic planning should be developed and consolidated, in terms of developing a clearer epidemiological picture for the country and in using data to plan for health needs and developments in service. This leads to an increased and more informed involvement in developments in public health, in coordination with other ministries, such as sanitation, housing, immunization and vaccination, health promotion and illness prevention.

Primary health care has been a major focus of activity on the part of the Ministry in recent years. Success stories include improved provision, increased awareness of patients, and acceptability of the services provided. Importantly, given the relative shortage of doctors working in areas outside the main conurbations, appropriate and well-organized training has been given to nurses working in the community. This affords a significant increase in the effectiveness of primary care provision. A continuing focus and development of primary care services – and their relationship with secondary care services – should be a feature of a revised structure for the MOH.

Although outside the scope of this report, some comments on the development of primary health care can be briefly stated. A considerable health gain could be achieved in the medium term if primary health care is developed as a formal clinical specialty. The return of up to 30 newly qualified medical graduates during the next year offers an outstanding opportunity to develop primary health care into a real community-based health system, providing continuity of care for the population and reducing the need for admissions to secondary care.

[9] Cf. Section 3.1 of the document *Health Sector Reform Proposals* published by the Ministry of Health, Human Services, Family Affairs and Gender Relations on 6 March 2002 in Saint Lucia.

If the Ministry concentrates on these key issues, it will afford an opportunity to develop other points that have been neglected, such as the development of standards for the provision of care; the development of regulations relating to public sector contracts; and the development of regulations governing private practice in Saint Lucia. The absence of such regulations and standards generates uncertainty and distrust between the main actors in health care provision. Concentrating on these issues – with the active participation of providers – will create a more open and trusting environment for all.

3.3.3. Universal health insurance as purchaser of health care

With the Ministry concentrating – for health issues – on the strategic development of health services, the standards and regulation of health care, and the provision of primary health care, the role of purchaser of health care should be divested to the organization responsible for the health insurance system. The focus is on the collection of contributions from contributors (workers and employers, usually, along with the government's contribution) and the purchase of health care on behalf of the beneficiaries (the total population, in the case of Saint Lucia). These roles are currently carried out by the NIC for the administration of the other social insurance programmes on pensions, employment injury, maternity, etc. In many countries the establishment of a social insurance scheme usually includes a provision for health care from the outset, so that the issue of where to "place" the health insurance organization is not an issue. It automatically forms a core part of the operations of the social insurance organization. In Saint Lucia there are many sound arguments for including the new universal health insurance system in the operation of the NIC. First, there is expertise and experience in collecting social insurance contributions so that only marginal additional costs would be involved in adding health to the contingencies already included in the NIC scheme. Second, the operational management and function of the NIC has built up a good degree of trust among contributors and beneficiaries. Third, it would add significantly to the expense of a universal health insurance system to establish a completely new organization which collects and maintains contribution records for a population base similar to that covered by NIC. However, neither NIC nor any other existing organization in Saint Lucia has in-house expertise in handling the purchase of health care or in negotiating contracts with provider hospitals which include clinical and care standards that are monitored. These skills would need to be developed in anticipation of the universal health insurance benefits becoming available. It is intended to provide secondary and tertiary care under the universal health insurance system, in the early years at least. This could be expanded to include all care, including primary and preventive care as the scheme develops and gains more experience in the purchase and monitoring of health care.

The proposed universal health insurance organization would also take over responsibility to purchase overseas health care on behalf of insured Saint Lucians. A budget of approximately EC$ 300,000 is currently assigned to overseas care and is acknowledged as significantly too low to meet needs that cannot be met through available health facilities in the country. However, there is evidence that whatever resources are available could be managed more efficiently by entering into contractual relationships (block contracts) with hospitals which have acceptable standards and can provide care not available in Saint Lucia. Under the health insurance arrangements, only patients for whom appropriate clinical care is not available would be authorized to access care in another country. The social insurance organization would not be liable for Saint Lucian patients who chose to access care abroad. Each patient would have to be authorized by the social insurance organization and by a clinical panel. The recipient hospital would need to be in receipt of a social insurance organization referral letter and the patient's medical records to ensure that the services would be paid by the social insurance organization. It is entirely appropriate that not all health care is available on a small island for a small population. Similarly, it is entirely appropriate that limitation of resources should be a factor in determining which illnesses and diseases can be covered through the universal health insurance fund. Some hard decisions may need to be taken about what can and cannot be provided under the insurance scheme.

The drugs and medicines bill currently amounts to EC$ 2.3 million (under the Agency Administration budget line). It reflects less than half of the spending in Saint Lucia on drugs and medicines. While there is central purchasing of drugs for the public sector, in such a small community it is recommended that a central purchasing authority would purchase on behalf of public and private

suppliers, with a better block-purchasing arrangement and better discounts. A first step to rationalization of the drugs budget is the development and acceptance of an essential drugs list, using generic drugs and medicines as the preferred first option. The Pharmacists Association agreed to develop a first draft of an essential drugs list by end of February 2003 followed by consultations between pharmacists, doctors and nurses, to finalize an agreed essential drugs list for the population. Under the universal health insurance system, a generic drug or medicine, when available, would be prescribed and dispensed, for example – unless specific contraindications, allergies or clinical indications are presented by the prescribing clinician that would warrant a brand-name drug. Patients who, for whatever reason, decide they want a brand-name drug rather than an equally effective generic are at liberty to purchase the drug from a private pharmacy. Educating the public on the effectiveness of generic drugs and medicines is an important behavioural change to develop in the patient population.

3.3.4. Revised allocation of government health expenditure

Reorganization in the health sector would clearly warrant changes to the distribution of the resources to the Ministry of Health. Table 3.1 shows how the new allocation of budgets could look. Based on current budget figures, the Ministry of Health receives EC$ 54.5 million. Deducting the budgets for elderly care, secondary care and for drugs leaves EC$ 47.7 million. The total budget available to the MOH for primary care provision, public health services, central planning and administration would amount to EC$ 15.8 million. This does not take into account the recognized resource gap in funding for some of these services, based on the health reform recommendations and estimated as EC$ 9 million. [10]

Table 3.1 contains only the core future allocation of resources to the MOH as estimated on the basis of the current health care budget. In addition to this core allocation the MOH might require additional funds for contribution subsidization or exemption for the poor. As long as no decisions have been made on how UHI will be financed, the total expected future budget of the MOH cannot be established.

Other resources of the total national budget for health would be allocated to provider units for the provision of care to the covered population and to the NIC for the administration of UHI.

[10] Refer to section 4.2 for further details.

Table 3.1. Revised core allocation of health budget under the proposed universal health insurance system (based on current budget allocations for public health care), 2003

Cost center	**Budget** (million EC$)
Agency administration	4.7
Corporate planning	0.5
Victoria Hospital	20.8
Soufrière Hospital	0.9
Dennery Hospital	0.6
Golden Hope Hospital	2.4
Turning Point	0.4
Human Services and Family Affairs	4.0
St Jude Hospital (grant)	8.7
Senior Citizens Home	0.5
Primary Health Care	5.7
Public Health	4.7
Gros Islet Polyclinic	0.6
Total	**54.5**
LESS:	
Human Services and Family Affairs	
Senior Citizens Home	
Drugs and medicines budget (EC$ 2.3 million) from Agency Administration line	6.8
Revised total MOH budget	**47.7**
Total budget for primary health care:	
Soufrière Hospital	12.9
Dennery Hospital	
Turning Point	
Gros Islet Polyclinic	
Primary Health Care	
Public Health	
Total budget for central planning and administration	2.9
Agency administration	
Corporate planning	
Proposed revised budget allocation for MOH under new universal health insurance system	**15.8**

Source: Ministry of Health, 2002.

3.4. Issues related to health providers under universal health insurance

Patients entitled to access care under the universal health insurance system would register with one of the hospitals accredited to provide care. At the outset of the scheme, it is anticipated that Victoria Hospital, St Jude Hospital and Tapion Hospital would all be accredited to have patients register with them. An upper limit on the number of patients for the capacity of each facility would be in place. Registration of patients would be by their own choice and would inevitably depend on where they live or work. Factors such as the residence location, work location and proximity of health services will be taken into account reflecting, where appropriate, the country's zoning strategy concerned with the organization of health services into northern and southern regions. Once a patient is registered with the hospital at the start of the scheme, the hospital would receive a capitation rate of one-twelfth of the annual capitation payment for each patient registered. If weights were in place at the outset, these would automatically be

taken into account in the calculation. [11] Patients would be issued with a card entitling them to secondary services at their preferred provider and the provider hospital would have access to a database which allows them to check if the patient is on their list of registered patients, is eligible to contribute to the universal health insurance fund, and if contributions are up-to-date. Those who are exempt from making contributions because of poverty, unemployment or other to-be-determined reasons would appear on the computerized database as fully paid-up contributors.

Patients would be entitled to change their provider once a year (or over a longer period) in order to ensure some very limited degree of competition among such a small number of providers. Providers would be required to accept patients onto their register irrespective of pre-existing conditions, illnesses or medical history: in health insurance the patient is not assessed on an individual risk basis but on the basis of being part of a risk group. Registration of patients would be done on a first-come, first-served basis by the administration in charge of universal health insurance, to ensure that provider hospitals did not select those who present less of a health risk than others. All patients would be entitled to be registered with a provider hospital. [12] Patients who are eligible to contribute to the scheme but who do not make contributions would be liable to pay for all health care costs out-of- pocket, direct to the provider.

Accident and emergency services would be funded directly through a block contract arrangement, based on historical activity data, to the two receiving hospitals. It would be inappropriate to include Accident and Emergency Services in the capitation payment since patients should access the nearest hospital in an emergency and may not necessarily be close to their provider hospital. The Government Special Task Force is studying the possibility of using allocations from the global health budget and other options to pay for pre-hospital care and hospital emergency room care.

In this context, one of today's problems in the utilization of secondary services should be noted. A large proportion of patients are accessing care through the Accident and Emergency Department, when their signs and symptoms would be handled more appropriately by a primary care provider. Improved use of both Accident and Emergency and an improved referral process would enable secondary providers to spend more of their time dealing with patients who actually need secondary care. Developing referral mechanisms agreed on between the providers of primary and secondary care (nurses, doctors and technicians) is an essential precursor to changing patient behavioural patterns and to the sustainable development of a universal health insurance system.

3.5. Capitation as the provider payment system under universal health insurance

There is a wide range of provider payment mechanisms available to the health sector. Medical practitioners are often compensated through fees for services, salaries paid by ministries of health, bonus payments and capitation fees. Hospital expenditure is normally met through the allocation of public budget resources.

Each of the provider payment mechanisms has its own strengths and weaknesses in relation to quality of services, administrative costs, or cost containment, for example. As with most aspects of universal health insurance, the choice of a provider payment mechanism or multiple mechanisms has to be based on the prevailing circumstances within a country: it is a matter of balancing different priorities. Under universal health insurance there is a clear responsibility of the purchasing authority to purchase the best quality of care available within finite resources. The fact that one organization would have the

[11] 'Weights' imply that an adjustment in the formula to calculate the capitation payment would be introduced to take account of the relative risks faced by providers, depending on the risk profile of the population registered with their institution. For example, it would take account of the higher health risks associated with the registration of a person whose age is above the national average age.

[12] It may be necessary to extend this to include other providers, for example pharmacists.

purchasing power for a population of 157,600 people puts it in a very powerful position. The clinical and buildings standards available to beneficiaries may be made part of the contract of services. Balance this against the fact that there are effectively two general secondary care hospitals, so the degree of competition is minimal.

Taking all of the provider payment options into account, it is advised to adopt a *capitation payment mechanism* as the main mechanism to pay for health care, with some "limited weights" for patients with chronic illnesses and diseases, very young or very old patients. The reasons for the choice of capitation as the payment mechanism are as follows:

- it is the least expensive of all the mechanisms to administer (therefore keeping to a minimum the administrative costs of the scheme);
- with the establishment and monitoring of standards as a component of the contracts with providers it is easier to balance the quantity and quality of services provided;
- it offers extremely limited chance of the "cost-creep" to which other payment mechanisms are prone; and
- it puts a degree of responsibility on providers to ensure that they are providing the most cost-effective care for patients.

There are, of course, potential downsides to the choice of capitation. For example, without standards explicitly incorporated into provider contracts it would be difficult to sanction providers about lower quality services. Also, without well-established primary care services available to the population, it will be hard (at least in the first years) to re-train patients to access secondary care only when their signs and symptoms actually warrant specialist intervention.

Experience of other systems and other countries, however (and from a wide range of practitioners and organizations) indicates clearly that capitation, with accompanying standards, offers the most cost-efficient provider payment mechanism currently available. Table 3.2 compares the various mechanisms available and outlines their pros and cons.

Table 3.2. Comparison of performance of different provider payment mechanisms

Payment system	Cost containment	Quality	Administration
Fee-for-service	Very poor	Very good	Very difficult
Case payment	Good	Fair	Difficult
Daily charge	Fair	Poor	Very easy
Bonus payment	Good	Good	Easy
Flat rate	Good	Fair	Easy
Capitation	Very good	Fair	Very easy
Salary	Fair	Poor	Easy
Budget	Very good	Fair	Easy

Source: *Social heath insurance: A guidebook for planning*, Charles Normand and Axel Weber, WHO/ILO joint publication, Geneva, 1993.

In addition to capitation as the prime payment mechanism it is suggested to incorporate a limited bonus payment into the contracts. This encourages providers to exceed the standards set. Similarly, a form of sanction should be incorporated into the contracts, to penalize providers who do not meet the standards set as acceptable. [13]

[13] See section 4.2 for further details.

3.6. Legal considerations related to universal health insurance

In the context of universal health insurance, two pieces of relevant legislation already exist. The National Insurance Corporation Act No. 18 of 2000 mandates the National Insurance Corporation to provide social security contingencies for the working population (and, in some cases, for the families of the insured). There is a provision within the broad legislation for the development of health as one of the benefits to be provided through the universal insurance mechanism. In terms of proposed developments (notably the expansion of the scheme to include informal workers) and in terms of the expressed goals for universal health insurance to be equitable and fair, the concept of solidarity as demonstrated by the social insurance legislation provides an appropriate basis for inclusion of health as a benefit.

The National Health Insurance Act No. 28 of 1996 has never been in operation. Review of the legislation has revealed a significant number of inaccuracies, contradictions and ambiguities. These include, for example, Part 1, Section 2 which reads: … "'child' means a minor who is of the age of 16 years …." This is clearly inaccurate. A second example, this time of ambiguity, is in Part 1, Section 2 which reads: "'family' of an insured person means … (c) the dependents". This section is supposed to provide definitions of those included in coverage. It does not specify if a dependent includes parents of the insured, children of the insured or other relatives living with the insured, or relatives who consider themselves dependent. A third example, taken at random from many other inaccuracies, is from Part III, Health Insurance Premiums and Benefits, Section 19 (2), which reads: "For the purposes of this section 'pensioner' means a person who is in receipt of a pension and who is not gainfully employed." This does not indicate the type of pension, whether employment-related, or a state, NIC or private pension. Part III Section 20 provides, in social insurance terms, a rather bizarre message, because it specifically excludes voluntary contributors from access to benefits. It reads: "Any person can make a voluntary monetary contribution to the Fund: but such a contribution shall not entitle that person to a benefit under the Act." This latter section may indicate a lack of understanding of the basic principles of social insurance. Voluntary contributors are encouraged to participate in a social insurance scheme, since they fall outside the usual employment routes through which people normally make contributions.

Irrespective of the very poor drafting of the National Health Insurance Act of 1996, the intention was to provide insured health care to large parts of the population. This intention is taken a large step further with the government's goal of providing universal coverage to the whole population with the associated contributory responsibilities and entitlements. Given that the National Insurance Corporation Act of 2000 provides for inclusion of health as a benefit, it is recommended that the spirit of the 1996 National Health Insurance Act be incorporated into a revised regulation within the National Insurance Corporation Act 2000. To this end, the ILO contacted the legal staff of NIC to indicate issues that need to be incorporated into a new regulation. The new regulation should clarify the aims and goals of a universal health insurance system as well as the contributory responsibilities of beneficiaries.

Legislation would need to be drafted – amendments to existing legislation only when improvements and restructuring are brought in – submitted, adopted and enforced in relation to the following aspects:

- universal health insurance coverage definition including the rights and obligations of the insured population;
- universal health insurance benefits provided;
- provider payment system on capitation basis under universal health insurance;
- quality control;
- framework for disclosure, reporting and monitoring of experience;
- appeals mechanism;

- regulations pertaining to the supervision of private health insurance: calculation of premiums, benefits, taxation and reserves;

- licensing of health care practitioners and facilities in relation to the categories of care provided; and

- the physical location of health care providers accessible to the population, accepted volumes of services, basis for contracting practitioners, fees for services where applicable, etc.

A review of the accreditation system is recommended subject to background studies that would support the need for introducing such a system.

Part 4 now takes an in-depth look at how to develop a workable financing strategy and structure.

4. Financing considerations

4.1. Start-up costs of a universal health insurance system

First, a decision must be made on the source of financing that will be made available to meet all start-up costs, for example, the expenses related to setting up new administrative functions to support the initial launching of the new universal health insurance system, including all forms of promotional campaign, recruitment of staff, training, etc. It is not clear at this stage what structure will be adopted to determine and meet the start-up costs. If the NIC is made responsible for administering universal health insurance then it may be easier to determine start-up costs based on the past experience of the National Insurance Board when it was originally set up in the 1970s.

The cost of the development activities associated with a universal health insurance system should not be underestimated, an issue the ILO discussed in some detail with a number of key players. Table 4.1 provides some crude estimates for start-up costs.

Table 4.1. Illustrative start-up costs related to the proposed universal health insurance system

Activity	Approximate cost (in EC$)
Appointment and payment of core staff	280,000
Training and skills development of staff	200,000
Integrated hospital information system: assessment of information needs, systems analysis, selection of system, implementation programme	3,000,000
Public awareness programme (various media and public meetings)	150,000
Provider awareness programme (publications and meetings)	75,000
Appointment, payment and training of Steering Committee [(a)]	50,000
Appointment, payment and training of Medical Subcommittee [(a)]	50,000
Development and execution of change management programme for hospital providers	200,000
Development and execution of skills development programme for universal health insurance organization staff	200,000
Information needs and system development for universal health insurance organization	1,000,000
Approximate total start-up costs	**5,205,000**

[(a)] Their activities are outlined in Part 2, Box 2.4 and Part 6, Table 6.1.

There has been no indication from Government about the sources of funds for the development work required for universal health insurance. Clearly it would be inappropriate to expect the NIC to continue to fund all of the development work for universal health insurance, since much of it relates to activities which should have been undertaken through Ministry of Health budgets. It is suggested, however, that the EC$ 3 million currently being given by the NIC to the health sector could more appropriately be redirected to support part – but not all – of the development work for universal health insurance. A separate commitment from Government to make up the shortfall of EC$ 2.2 million would also be required.

4.2. Projecting health costs under universal health insurance

Under the proposed universal health insurance system, it would be ideal if the development of health budgets and capitation fees were determined on the strict method of capitation. The basic idea of estimating the capitation fee is that it should roughly equal the average medical cost in respect of the benefits' package provided by the universal health insurance system (probably excluding administrative costs). The figure would likely be subject to various uncertainties. The effects of behavioural changes on the utilization rate and unit cost rate are very difficult to evaluate under a new universal health insurance system. Once launched, it may lead to a more frequent use of medical care than when no such system existed.

Technological advances can also affect the price of various medical services, either positively or negatively. In view of the inherent difficulty of such an analysis and in the absence of empirical evidence, the average medical cost is considered an adequate benchmark of the capitation fee.

The capitation fee can normally be broken down into components related to the key benefit categories covered by the new universal health insurance system:

- outpatient care (OP);
- inpatient care (IP);
- health prevention and promotion (HPP);
- high-cost care (not included in the basic package of benefits but insured) ;
- accident and emergency health care (A & E); and
- capital investment (INV).

The unit cost for OP and IP is set as U (i) and the incidence rate (morbidity rate) is set as M (i). For the other health components, the average *per capita* cost is estimated. Where all necessary data is available and reliable, the capitation fee should be estimated as follows:

$$\text{Capitation} = U_{OP} * M_{OP} + U_{IP} * M_{IP} + CAP_{HPP} + CAP_{\text{High Cost}} + CAP_{A\&E} + CAP_{INV}$$

The method used by the Government Special Task Force to determine the health budget to be covered by the proposed universal health insurance system does not explicitly account for health expenditure data as described above for calculating capitation fees and resulting budget health expenditure for a universal health insurance system. This is largely due to the lack of a reliable database on morbidity. Data collected through the HERA Costing Study, e.g. unit costs related to inpatient and outpatient services, could allow some components of the capitation formula to be developed. The Government Special Task Force has developed an adaptation to the above formula to duly account for the lack of data by using observed historical utilization data to reflect the incidence rate assumption. Future incidence rates under the prospective universal health care system will likely vary from past utilization patterns: there may be a higher incidence in future as the behaviour of patients will not be constrained by have or do-not-have insurance considerations although the take up rates will gradually increase in the implementation period. Consequently, the Government Special Task Force may wish to adjust the database derived from the Hera Costing Study to include a margin for such discrepancy. Within one year from inception of the new universal health care system, there should be a detailed analysis of incidence rates and how patterns are projected to evolve. The capitation formula should be adjusted accordingly. Providers should be aware of this situation and do their best to assist in compiling the database. The adaptation of the capitation formula by the Government Special Task Force is presented in Annex 3 of this report for illustrative purposes only.

Efforts should be made to develop a high quality and comprehensive health information system that will ensure the accurate calculation each year of the capitation formula. Also, tools should be developed to provide cost projections in the short and long term. Such cost projections are essential to monitor and take advance measure to prevent escalating health expenditure and to manage effectively the income sources to the universal health insurance system.

Table 4.2 shows the current available resources (income) and the anticipated need (expenditure) based on both the HERA Costing Study and the health reform proposals. As mentioned previously, in the

absence of an accurate and detailed costing mechanism in the health sector, the figures cannot be proved absolutely precise. Based on the ILO's calculations and observations they are deemed to be within acceptable parameters. [14]

Table 4.2. Budget estimates for the universal health insurance system based on 2000 data
(million EC$)

Health services	Proposed universal health insurance funding	Required government funding [a]
Expenditure estimates		
➢ Victoria Hospital	22.3 [b]	20.8
➢ St Jude Hospital	15.0 [b]	8.7
➢ Golden Hope Hospital	3.4	2.4
➢ Drugs and medicines	3.3	2.3
➢ Development of services *"new item"*	5.0	-
➢ Overseas referrals	1.5	0.3
➢ Universal health insurancecontingency fund [c] *"new item"*	2.5	-
➢ Administration *"new item"*	2.5	-
Total expenditure	**55.5**	**34.5**
Revenue estimates		
Resources expected from current Government funding	34.5	
Resources to be collected from insurance contributions	21.0 [d]	
Total revenue	55.5	

[a] The required government funding amounts refer to transfers to be made directly to the universal health insurance system; these differ from the budgetary allocations made to the Ministry of Health directly. [b] These figures are different than related the ones provided by the Government Special Task Force as of June 2003 and presented in Annex 3. [c] This represents an expenditure item to be incurred in first year only and its level should be maintained in future years. [d] The Government Special Task Force has been revising the estimate for resources to be collected from insurance contributions.

The figure of 21 million in Table 4.2 would at the same time indicate the amount of contributions to be collected in the first year from various types of contribution incomes under the UHI and as a calculative base for the estimation of overall average capitation amounts. As the level of the contingency fund only requires maintenance but no further build-up in future long term expenditure might be slightly lower in later years in real terms under *ceteris paribus* contributions. As specified above, estimated revenue from insurance contributions are revised at the moment by the Government Special Task Force. Based on a total population of 156,700 this would amount to an annual *per capita* capitation (roughly equal to annual *per capita* contribution) of EC$134.1 *per capita*. The average contribution could be decreased if substantial user charges could be collected from users of health facilities. Such charges would have to be very carefully designed, so that no new harmful barriers to access would be erected in the system. They are not explored here in more detail.

All the figures in Table 4.2 are indicative only and rely on external sources and estimates. It is strongly recommended that Saint Lucia undertake a complete national health budget analysis [15] before is finalizes the definitive regulation of a UHI.

[14] For further details on health expenditure and financing, see sections 3.3.4 and 3.5 of the present report.
[15] As described for example in Cichon et al.: *Modelling in health care finance*, ILO (1999), Chapter 5.

4.3. Financing options

This section assesses what additional sources may be available to collect necessary resources. Classical insurance contributions are not the only option to collect income for what is essentially a national health insurance scheme. Given the size of the country and issues surrounding revenue collection, the robustness of the tax system and overall economic factors, a number of possible other options arise. Some options will be more feasible than others, given the prevailing political circumstances in the country. Some will be more politically acceptable than others, given election promises and commitments. And some may be more acceptable to certain groups in the population, given the historical benefits and entitlements to which people have become accustomed. The ILO has based its recommendations on the terms of reference given: rule nothing out and rule nothing in. Each of the options proposed incorporates solidarity and equity – key features of universal health insurance – and each option presumes a continued level of financial commitment by Government to health services.

4.3.1. Universal health insurance financing: Option 1 – General taxation

A first option is to collect a tax through a utility bill. All of the main utilities are available to every household: if there is a household without a utility it indicates a degree of poverty that would automatically exempt the family from contributing to the social insurance scheme. The obvious utilities which could have a percentage added to them to contribute to a universal health insurance fund are electricity, water and telephone. This option has the benefit of fairness and solidarity: those with large houses would use more of any utility and would therefore contribute more to a utilization-based fund. It has the disadvantage of adding to the cost of a necessary utility but it reinforces the fact that health care is not a free commodity. It is the responsibility of all those who can afford to do so to contribute to the cost, if health services of an appropriate quality and quantity are to be available.

Another option is to use (with a proposed increase) the existing environment levy to accrue resources for the universal health insurance fund. The environment levy currently accrues EC$ 7 million. It is proposed to increase this from 1.5 per cent to 5 per cent to accrue up to EC$ 25 million and to direct the total to the universal health insurance fund. This option has the advantage of having a collection mechanism already in place and working well. It has the potential disadvantage of stretching the acceptability of the tax in the public mind by increasing it and expecting it to provide resources for a wide range of activities and strategies. In addition, it should be noted that the resources derived from such an increase in taxation may not remain stable over time, especially if consumption of services decreases during an economic downturn – thus producing less revenue when there is likely to be an increased demand for health services.

4.3.2. Universal health insurance financing: Option 2 – Contribution collection

The second option would be to include health as one of the contingencies administered by the NIC (although it could be a separate scheme from a legal perspective) and collect contributions from the NIC members to go into a universal health insurance fund. This is found in countries either embarking on a social security scheme or further developing one. In many instances the contributor would be entitled to health benefits and the dependents of the contributor (spouse and school age children) would also be entitled to access health benefits.

Collecting contributions from the NIC contributors alone has the advantage of being relatively easy to administer: a registration and contribution system is already in place and operating. It has two potential disadvantages: (a) that only those who contribute to the scheme would have cover under the health insurance arrangement (thus not complying with the basic premise of universality); and (b) that the burden of additional resources for health care for the whole population would unfairly rest on the shoulders of those working in the formal sector, if the whole population are to be entitled to access.

Those who are working in the informal economy, many of whom could afford to contribute to the insurance scheme, would not be contributing. This situation could be resolved by including informal

economy workers in the mandatory contribution obligation to the UHI scheme. The contribution scheme would thus be more equitable and create a strong degree of solidarity (Box 3.1 maps out a way to do this). However, without a detailed household income and expenditure survey, it is not clear how much revenue this would generate.

4.3.3. Universal health insurance financing: Option 3 – Combining a menu of possible choices

A compromise option for this scheme is a mix of all of the above. Until the social security scheme is fully expanded and therefore able to boast a high degree of solidarity for a universal health scheme, a system could be put in place whereby funding for the universal health insurance system could come from a range of sources.

Still assuming the government's commitment of EC$ 34.2 million for secondary care and assuming the shortfall of resources for implementation of a universal health insurance system to be approximately EC$ 21.00 million, the following resources could be accrued using a variety of collection mechanisms:

(1) A contribution of 4 per cent on insurable earnings from the currently legally insured workers under the NIC (2 per cent each from employers and insured employees) would accrue EC$ 21.2 million.

Note: This option would likely receive limited support from employers as it would be perceived as negatively impacting on the business sector.

(2) A contribution of 3 per cent on insurable earnings from the currently legally insured workers under the NIC (1.5 per cent from employers and 1.5 per cent from insured employees)

plus

a flat rate contribution of EC$ 33 per month from informal economy workers (not currently legally covered by the NIC). This would accrue EC$ 22.0 million.

Note: This option is considered relatively fairer as all individual income earners would contribute to the universal health insurance system. However, the identification and registration of the informal workers is difficult and so is devising an effective way to collect their contributions.

(3) An 11 per cent tax on electricity usage would accrue EC$ 17.6 million, based on current utilization, EC$ 4.6 million from the current environment levy plus an 8 per cent tax on electricity usage would accrue EC$ 17.4 million.

(4) A 3 per cent contribution from current NIC contributors – 1.5 per cent from employers and 1.5 per cent from employees plus the environment levy of EC$ 4.6 million with a further 20 per cent added (i.e.120 per cent of current levy) would accrue EC$ 21.4 million.

(5) A 3 per cent contribution from current NIC contributors, plus a 1.5 per cent contribution from salaries of civil servants, plus the current environment levy with an additional 20 per cent would accrue EC$ 23.3 million.

(6) A 3 per cent contribution from current NIC contributors, plus a 3 per cent contribution from civil servants (split in both cases between employer and employee), plus the environment levy with an additional 20 per cent, would accrue EC24.3 million.

Each of the fund accrual mechanisms has its own merits, but not all of them will accrue sufficient resources to make the universal health insurance system sustainable. Sustainable sources of funding are crucial to long-term sustainability of the scheme and further development of health services.

Discussions with key players provided a number of opportunities to discuss the merits and demerits of the various funding options. In the short to medium term at least, the preferred option of key players seems to be the amalgamation of a contribution from formal sector employers, employees and civil servants, plus the resources accruing from an increased environment levy. On the negative side, there is some question over the longer term feasibility of the environment levy, the absence of which would inevitably lead to an increase in the contribution rate for employers, employees and civil servants. On the positive side, the expansion of the social security scheme to include informal economy workers will provide an opportunity to create real solidarity, whereby *all* of those who are earning would contribute to the scheme, thus subsidizing those who are too young, too old or unable to work. In terms of financial revenue, this option (even if less than perfect) forces the expanding informal economy to face social security and health contributions and would seem to have major advantages from the perspective of long-term governance.

Part 5 explores the factors that are critical for achieving a new universal health insurance system in Saint Lucia.

5. Prerequisites for successful implementation of universal health insurance

The political decision and will to implement universal health insurance is the chief factor for success. In Saint Lucia, political support is strong but there are issues which, if not handled correctly and at the right time, could cause universal health insurance to fail. Most of these issues are mentioned elsewhere in the text of the report. They are highlighted here to reflect the interdependence of a number of apparently marginally unrelated issues.

5.1. Parallel proactive implementation of the national health programme

A universal health insurance system cannot be planned and implemented in a vacuum. There are many issues which impact on its feasibility. Implementation of the national health reform programme, as presented in 2000, is a linchpin to the success of universal health insurance. The reforms proposed and detailed in the government's health reform document must be implemented – preferably in anticipation of (or, at the very least, in tandem with) the development and implementation of a universal health insurance system.

None of these reforms will be easy. People do not, as a rule, welcome change even when they know it is necessary. Implementation of some of the reforms will expose significant gaps in the capacity of some of those who plan, manage and provide health care in Saint Lucia. Sensitive handling and management of the reform programme is essential. For example, ownership of the required changes must be developed at all organizational levels before any significant changes can be undertaken. It must be made clear to all involved (at all levels) that changes need to be made if the health service is to provide the quantity and quality of care deemed appropriate for the people of Saint Lucia.

The health reform programme has been accepted by all key players as the right way to proceed to develop a modern and responsive health system. Its implementation has been slow and unsystematic. The reform process cannot continue to be implemented on a sequential basis. It is certainly an ambitious programme – another reason that it must be undertaken cohesively, tackling a range of issues at once and under the direction and leadership of a small team who understand and are working towards a cost-efficient service. There simply are not enough people with the appropriate expertise and experience in the health sector to be able to achieve this in a relatively short time frame.

5.2. Role of the Government Special Task Force

The Government Special Task Force should remain responsible for implementing all necessary universal health insurance preparatory work and should implement capacity-building recommendations to ensure capable human resources are available at all levels of intervention, especially among providers, in a timely manner when the new universal health insurance system is introduced.

5.3. Establishing an information culture

Four issues are at stake here:

- improving the database on epidemiological picture
- better cooperation among health partners
- an integrated hospital information system
- the national health insurance information system.

The key to developing an understanding of the clinical implications of financial decisions and to understanding the implications of planning options and decisions must be based on good quality information. This cannot be overemphasized. The development of agreed and accepted data sets is the responsibility of all of the health care personnel who are expected to manage resources: financial, human, skills, supplies, drugs, patients, equipment and service development. There has to be an understanding of the balance between the desire for service development, the provision of the best possible quality service within finite resources and the management of those resources. Every member of the health team has a responsibility in relation to this. An information culture is one in which the language used is understood by *all* involved: it is not exclusive to one group. Inevitably, differences will occur in the interpretation of the data and information available. But the critical factor is that all decisions taken are based on accurate information rather than on gut instinct or, worse, the ability of some to articulate their needs and demands better than others.

The basis of an information culture in Saint Lucia hinges on the development and implementation of an integrated hospital information system. This would be the basis for all operational and strategic decision-making about secondary care. There are a tiny number of individuals who understand the underlying issues and the interrelationships of data. It is recommended that external assistance be sought to help define the information needs that will provide a functional hospital information system. There should be no need to reinvent the wheel on this: considerable expertise is available in these types of system. One word of caution would be to advise the hiring of a consultant or consultant team experienced in social or public health schemes – as opposed to private health schemes. A short list of individuals who would be appropriate to take on this task on behalf of the health sector have been suggested to the Task Force.

5.4. Improving clinical and buildings standards

Acceptable clinical and buildings standards need to form a core part of a contractual relationship between purchaser and providers. Without such standards, it will be impossible to monitor and control the quality of patient care. The purchaser of health care can use them as the main indicator of adherence to (or breach of) the contract of services. Accepted clinical and buildings standards also provide patients with a clear understanding of what they can (and cannot) expect when accessing secondary care services. In the case of a patient's query or complaint about services, the clinical and buildings standards offer a clear-cut and independent gauge.

It may not be necessary to develop clinical and buildings standards from scratch: the existing ISO standards offer a possible route to agreeing on standards for universal health insurance in Saint Lucia and getting them in place quickly. Indeed, the implementation of agreed standards should be a precursor to the implementation of the universal health insurance system. Providers can thus become familiarized with the concepts, application and monitoring of both clinical and buildings standards, leading to an acceptable quality assurance programme.

5.5. Launching a communication strategy

The introduction of a new universal health insurance system should not neglect the importance of public information and education in order to raise public awareness and acceptance for the new system. This bears significant impact on the motivation of the officials in charge of implementing the new universal health insurance system.

In addition, a communication strategy targeting exchange of information and effective flows of information among health partners and professionals and institutional programmes should be devised.

5.6. Licensing and accreditation of doctors, linked to a continuing professional development programme

With the limited number of clinicians and nurses available in Saint Lucia, it is crucial to provide ongoing professional skills development and to maintain up-to-date techniques. The availability of a continuing medical and nursing education programme should be part of any contract with doctors and nurses providing care to patients – it should not be a voluntary or optional issue but be clearly linked to accreditation and licensing. The programmes for continuing professional development need not be available in Saint Lucia. [16] It could be developed in close liaison with postgraduate medical schools and specialty peer groups. Advice on the components of professional development programmes and continuing medical education programmes are available from specialist clinical and nursing groups in most developed countries. (Advice and contact suggestions on useful organizations is available if required.)

5.7. National identification and unified registration measures

In order to ensure that all of those who should be contributing are doing so, it will be important for everyone who accesses the universal health insurance system to have a unique personal identifier. A unique number offers the means of capturing data, which can then be presented anonymously, relating to health status of the population, incidences of outbreaks of disease or illness, utilization of health resources. The National Insurance Corporation unique personal identifier is currently issued to all contributors to the social insurance scheme. Those who apply for a passport are also required to have an NIC number. The NIC number could become the national identification number for all – showing entitlement to access health care and also, for those who are eligible to contribute, to indicate whether or not contribution payments are paid up and valid. Those who are eligible to contribute to the resource pool of the universal health insurance system would be entitled to access secondary health services free at the point of delivery, whereas those who can be shown not to have made their contributions would be held liable to pay for health care directly to the providers. A quick reckoning would indicate to most people that the cost of contributions, either on an individual basis or in relation to a contributor's family, is significantly lower than if they had to pay directly for their health care.

[16] Such a small number of specialist clinicians would not be remotely feasible.

6. Milestones for the successful implementation of universal health insurance

Despite its small size and small contribution base, Saint Lucia is in an enviable position – it already has in place many of the difficult and time-consuming preparatory activities required to establish social insurance schemes. The learning curve for universal health insurance will be steep, since this is a new provision and a very different way of operating. But because of the existing arrangements it is possible to reduce the preparatory and planning phases for universal health insurance to two years, rather than the usual three to four years recommended in many less-developed countries.

Many of the skills necessary to undertake the development work and the effective and successful operation of a universal health insurance system are not available in Saint Lucia. In the first instance, consultancies will need to be brought in, to provide transfer of skills and knowledge. At the outset, it is crucial to appoint a small team who can be developed and will grow into senior roles in universal health insurance. Based on discussions with key players, some suggestions have been made as to those who might fit the bill for a number of the key roles. Those suggested are keen and enthusiastic about universal health insurance and are knowledgeable about wider health issues. It would be inappropriate to assume, however, that each of them is equipped to walk into the role and immediately respond as fully competent staff members. Each of the proposed core team will need intensive exposure and skills and knowledge development to bring them to the level of competence required to carry out the demanding technical role which will be required of them.

The list of activities and the timetable presented in Table 6.1 are not exhaustive. The activities, as identified, follow a logical sequence, but they are indicative rather than entirely prescriptive. Many issues not mentioned in the context of this report will arise during the course of the development period and during negotiations with the various key players. It would be impossible to predict every eventuality. But it is fair to say that this timetable is an optimistic one – and one that depends equally on the political will and the preparatory (or pump-priming) resources being available to facilitate all the necessary development work. Without both of these factors, the timetable will quickly become unworkable and untenable.

Table 6.1. Countdown: Proposed activities prior to implementing universal health insurance in tandem with timetable for implementation of health reform

Milestones	Activity	2003	2004	2005
1.	Establish the core team in charge of universal health insurance organization.	****		
2.	Establish health insurance Steering Committee.	****		
3.	Establish two year development and education programme for health insurance team (including study visits and intensive training).	****	****	*
4.	Agree on 2-year strategy for planning and implementation programme.	****		
5.	Develop integrated hospital information system (External assistance to determine information and technology needs and plan for implementation). Implement hospital information system.	****	****	****
6.	Determine those services that will and will not be provided under a universal health insurance system.	****		
7.	Agree on basic clinical and buildings standards.	****		****
8.	Develop and introduce public awareness programme, including the communication of a marketing strategy.	****	****	****
9.	Agree on the essential drugs list (Pharmacy Association, doctors and nurses).	****		****
10.	Determine the information needs for the organization in charge of universal health insurance (for contribution collection and reconciliation, contracts, monitoring, development of services, planning etc). Implement the universal health insurance information scheme in coordination with hospital information system.		****	****
11.	Develop and introduce provider awareness and education programme (universal health insurance principles, accreditation of providers, contracts, standards, financing etc).	****	****	****
12.	Facilitate development of skills of senior hospital mangers (management, financial management, clinicians, nurses and technicians) External assistance required to undertake change management programme.	****	****	****
13.	Revise social insurance legislation and universal health insurance legislation to comply with new arrangements.	****	****	
14.	Develop, draft and process the new regulations required to facilitate the development of universal health insurance.	****	****	
15.	Determine the financing strategy. Determine the contribution rate for employers and employees, the rate for other levies and taxes. Develop weights, if being used, for capitation.	****	****	****
16.	Develop and establish intensive skills development programme for the staff of the administration in charge of universal health insurance (registration, contribution collection, validation of entitlements, contracts with providers, standards of care, quality assurance, complaints, sanctions, payment of providers etc).		****	****
17.	Register all beneficiaries and assign unique personal identifiers.		****	
18.	Determine contribution rate (from different sources) and register all contributors.		****	****
19.	Register beneficiaries with chosen secondary providers.		****	****
20.	Establish block contracts with overseas providers (for clinically necessary care not available in Saint Lucia).		****	****

Table 6.1. Countdown: Proposed activities prior to implementing universal health insurance in tandem with timetable for implementation of health reform (cont.)

Milestones	Activity	2003	2004	2005
21.	Develop contracts with hospital providers, including standards to be applied in monitoring of contacts.		****	****
22.	Start collecting contributions/ levy/taxes and lodge in universal health insurance fund.		****	****
23.	Establish mechanisms for enforcement of payment by those eligible to contribute, including ensuring that the computerized systems enable provider hospitals to track and identify those not making contributions.			****
24.	Appoint Medical Subcommittee of Steering Committee (referral arrangements between primary and secondary care; authorization for overseas treatment; clinical complaints, authorization for paying from clinical services not included in the capitation fee, etc). Establish training programme.		**	****
25.	Establish the governing body of the universal health insurance system of Saint Lucia.		*	****
26.	Ensure referral arrangements are in place between primary and secondary providers (Medical Subcommittee, providers and MOH).			****
27.	Establish provider payment mechanisms and start payments (and arrangements for bonuses and sanctions).			****

Within the context of these strategic proposals in Saint Lucia are some highly positive issues and developments in the current health system that will contribute to the successful implementation of universal health insurance. Equally, there are some negative issues that will work against successful implementation unless they are constructively addressed.

On the plus side, is the body of analytical work that has already been achieved by the Government Special Task Force on health insurance, including consultations with a range of stakeholders (trade unions and associations, pharmacists, doctors' associations, nurses' groups, hospital managers, private practitioners and private health insurers). This gives the Task Force team a head start of at least a year and places them in a good position to tackle the planning process for implementing universal health insurance. A second plus is that the health reform programme already exists. It is a key element in ensuring that the health system in Saint Lucia is modernized and focused on making the most effective use of limited resources. The government-accepted 2000 document on health reform is a sound and solid piece of work that now needs to be translated from paper into action.

A concerted effort is required to implement the recommendations of the health reform programme in tandem with the preparations for implementation of universal health insurance. Few people in health management in Saint Lucia have sufficient knowledge of modern information-led management practice. Based on ILO experience in many other countries, it will be extremely difficult and risky to undertake the change management activities necessary without external expert assistance. Traumatic as change management can be, such assistance would serve as a strong investment for future management practice. There is a small cadre of very committed people in Saint Lucia who want the country's health services to meet the population's health needs in a cost-effective and sensitive manner. Facilitating these individuals to work together would form a core team for the planning and development of the health system to implement universal health insurance. While they would be missed from their current roles, this can be seen as an investment in the long-term improvement and responsiveness of the health system, given the small size of the population.

Unfortunately, a number of core issues counterbalance the positive aspects. The system has only a limited capacity to translate policy into practice. This stems from an environment where the management of health services is not perceived as a dynamic process – as evidenced by the relatively slow implementation of the health sector reforms. The success of the proposed universal health insurance system *depends* on the implementation and activation of the health reform process. A new financing mechanism implies a new culture in the delivery system. This issue bears emphasizing and features in this report as one of the critical factors for success.

The Ministry of Health is overwhelmed with the range and number of activities for which it is responsible. Currently the Ministry is acting as strategic planner, health needs assessor, custodian of health statistics, financial planner, purchaser of health care, monitoring of health provision, contracting with individual clinicians and much more. Owing to its limited capacity (both in staffing and skills), this report recommends that the Ministry should focus on activities to reinforce its strategic role and to support improvements in the field of primary health care – an essential factor in the development of a more responsive health service. This strategic role should include health needs analysis and development planning, as well as establishing clinical and buildings standards for health provision.

The development of contracts with clinicians, an issue currently exercising the doctors' association and the Ministry, may well be resolved through augmenting autonomy for secondary hospitals, which could be a side-effect of the introduction of the new third-party payment system in the sector through universal health insurance. It has clearly been observed that improvements in the quality of care and care management are required in each of the secondary hospitals. Part of this problem could also be solved by building a performance-based aspect into the provider payment system under universal health insurance.

It is evident that the wider health sector reforms and the reform of the health financing system, with its dual capacity to:

- increase the resources base of the sector, and
- develop an incentive structure for health professionals through its provider payment mechanism (for a positive impact on the management and delivery of care) need to be provided in tandem.

To achieve this desired outcome in Saint Lucia, the challenge is in finding fair and equitable ways of financing health care to ensure a continuing improvement in health status for the population.

Annex 1. Papers and documents consulted

Economic and Social Review 2001, Ministry of Finance, April 2001

National Insurance Corporation Annual Report 2001

National Health Insurance in the Eastern Caribbean: A Guidebook for Appraisal and Design, PAHO/Who, May 2002

Social Health Insurance: A Guidebook for Planning, Normand and Weber, WHO/ILO, 1993

Ad-hoc reports from National Insurance Corporation statistical department

Minutes of Government Special Task Force meetings

St Jude Hospital Act

Golden Hope Hospital activity statistics

Mission report, Derek Osborne, ILO, October 2002

Health Sector Reform Proposals, Ministry of Health, Human Services, Family Affairs and Gender Relations, March 2000

HERA Health Sector Study, Final report and recommendations, Phase 2, January 2001

HERA Health Sector Study, Client Survey Report

HERA Costing Study Report, all volumes, November 2000

National Health Insurance presentations to various stakeholder groups

National Health Insurance Concept paper, Special Task Force, 2002

Report of consultations with health workers and major stakeholders, December 1998

Discussion paper on health sector reform, June 1998

Annex 2. Contacts made for the purpose of this study

Carmen Alexander	Pharmacy Association
Vincent Alexander	Pharmacy Association
Yasmin Alexander	Health Claims Adjuster, Jeffrey and Jeffrey
Arletta Bailey	Managing Director, Jeffrey and Jeffrey
Bibiana Baptiste	Nursing Officer, St Jude Hospital
Damian Biscette	Chamber of Commerce
Priscillia Busby	Nursing Officer, Victoria Hospital
Kathleen Cadette	Executive Secretary, Insurance Council
Clinton Charlery	Branch Manager, GTM
Celestine Emanus	Financial Analyst, Ministry of Health
Angela Fanis	Psychotherapist, Golden Hope Hospital
Clotilda Jenny Février	Deputy Hospital Administrator, Victoria Hospital
George Goddard	General Secretary, General Workers Union
Hon. Damien Greaves	Minister of Health
Claude Griffith	NHI Task Force, Chartered Accountant
Milton Haripaul	Supervisor for Group Department, GTM
Emma Hippolyte	Chairperson of Prime Minister's Special Task Force
Susannah Jolie	Principal Nursing Officer, Ministry of Health
Paul Kallicharan	Statistician, NIC
Stephen King	Member of Task Force and Chairperson of NHI Committee
Randy La Force	Branch Supervisor, Clico International Life
Cynthia Labadie	Civil Service Association
Patrick Lammie	Principal Nursing Officer, Golden Hope Hospital
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Andrew Richardson	General Surgeon, Tapion Hospital
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Ian Simon	Hospital Administrator, Tapion Hospital
Sister Whitfied	Hospital Administrator, Golden Hope Hospital
Fidelis Williams	Permanent Secretary, Ministry of Health
Edmund Xysta	Planning Department, Ministry of Health

Annex 3. Adjustment of the capitation formula at time of implementation of universal health insurance based on the methodology developed by the National Health Insurance Task Force - to account for missing morbidity data -

The following is a proposed alternative application of the capitation formula using historical utilization data as collected by the HERA Costing Study as developed by the Government Special Task Force, namely Dr Stephen King. This is justified on grounds that there is no sufficient information to develop morbidity rates as presented in section 4.2 of the present report.

The capitation formula needs to be applied at the onset of the new universal health care system by using preliminary data adjusted to reflect projected utilisation. The latter can only be based on an analysis of the morbidity profile of the population of Saint Lucia – as all of the population will be covered – and taking account of the health services to be made available through the new universal health care system.

It is expected that a high quality and comprehensive health information system will be set up and will provide the necessary information on health services to the population to develop a thorough re-calculation of the capitation formula within the initial year of implementation of the universal health care system based on the theoretical formula.

There should also be tools in place to develop cost projections in the short and long term. The Government needs to have a clear vision of future health expenditure to be borne by its general budget and by the population through the selected financing mechanisms.

The above is in line with the objectives of the Government Special Task Force.

Table A3.1. Selected unit costs according to the HERA Costing Study (2000)

Health provider	Category of health service	Indicator	Cost (EC$)						Final Unit cost (EC$)	Adapted values Total for SJH
			Personnel	Drugs, med. supplies, reagents, xray, gas	Office, utilities, energy, small equipments	Maintenance	Miscellaneous	Depr.		
VH	A&E	Visit	104,5	27,0	6,3	2,3	1,5	0.0	141.6	141.6
SJH	ER	Visit	102.8	18.6	5.6	2.2	2.4	2.8	134.4	151.2
VH	OPC	Visit	95,4	45,3	7,4	4,3	2,4	0.0	154.8	154.8
SJH	OPC	Visit	77.10	13.4	8.7	3.1	3.0	4.5	109.8	117.7
VH	M/O	Patient Day	302,8	21,9	22,7	5,4	12,3	0.0	365.1	365.1
SJH	M/O	Patient day	271.5	22.4	24.4	6.7	26.2	12.9	364.0	369.3
VH	MED	Patient Day	212,8	27,8	12,7	3,4	7,9	0.0	264.6	264.6
SJH	MED	Patient day	179.3	24.5	26.9	7.3	26.1	14.7	278.8	287.1
VH	OT	Intervention	826,5	218,1	29,4	5,4	11,3	0.0	1,090.8	1,090.8
SJH	OT	Intervention	713.4	89.8	29.3	32.4	14.6	15.2	894.8	1,067.8
VH	PAED	Patient Day	270,3	25,8	16,5	4,5	10,4	0.0	327.4	327.4
SJH	PAED	Patient day	301.5	15.1	32.6	9.0	28.8	17.7	404.6	413.9
VH	SURG	Patient Day	239,2	43,8	13,7	3,9	10,3	0.0	310.9	310.9
SJH	SURG	Patient day	178.8	16.6	23.9	6.4	25.3	13.1	264.1	277.2

VH: Victoria Hospital, SJH: Saint Jude Hospital.

Adjusted Capitation = $U_{OP} * M^{adj}_{OP} + U_{ER} * M^{adj}_{ER} + U_{IP} * M^{adj}_{IP} * \#Days + U_{OR} * M^{adj}_{OR}$

U(i) = Unit cost (OP = out patient, IP = inpatient, OR = operating room)

$M^{adj}(i)$ = Historical utilisation rate (substituted for morbidity projected utilisation rate)

In addition to the replacement of morbidity rate by historical utilisation date, the adjusted capitation formula contains the following adjustments:

- an implicit assumption is made in respect of capital investment in each of the unit cost by type of health services (cf. next paragraph);
- the capital amount for accident and emergency health care is reflected in the unit cost for hospital emergency room care;
- pre-hospital emergency services are removed as they are to be covered through the government's global health budget;
- the capital amount for health prevention and promotion is removed from capiation as it is to be covered through the government's global health budget; and
- the capital amount for high cost health care is not included.

According to the HERA Costing Study, unit costs refer to support and direct clinical services. They reflect actual expenditure for health services, maintenance costs and investment for depreciation. The universal health care system however anticipates setting up an investment fund specifically earmarked for the improvement of existing health services. A further study will have to determine the level of details to be integrated into the allocation of the investment fund. For illustrative purposes, the cost per bed-day has been averaged to EC$290. It could be further broken down according to categories of health services in relation to paediatrics, standard medical services, surgery, gynaecology and obstetrics.

Table A3.2. Hospital utilization rates according to the HERA Costing Study (2000)

Health service	Hospital utilization rates	
	Victoria Hospital	Saint Jude Hospital
Outpatients		
Number of outpatient visits per 1,000 inhabitants per year	377	682
Number of new outpatient visits per 1,000 inhabitants per year	266	?
Inpatients		
Number of admissions per 1,000 inhabitants per year	81	87
Number of admissions per bed per year	46	56
Number of inpatient days per bed per year	199	219
Number of inpatient care bed-days *per capita*	0.35	0.34
Bed occupancy rate (in %)	54%	60%
Average length of stay all wards combined (in days)	4.2	4.8
Imaging Department		
Number of Xrays per 100 (new) outpatient cases[1]	37	17 (24)
Number of Xrays per 100 admissions	25	26
Laboratory		
Number of lab tests per 100 (new) outpatient cases[2]	281	229 (327)
Number of lab tests per 100 admissions	268	850
Obstetric deliveries		
Percentage women delivering at the hospital	87%	75% [3]
Percentage of deliveries with surgical intervention	8%	?
Operating facilities		
Number of surgical interventions per 1,000 inhabitants per year	18.2	19.0
Number of major & intermediate interventions per 1,000 inhabitants	14.5	11.9
Casualty department		
Number of casualties per 1,000 inhabitants per year	237	193
Number of injuries per 1,000 inhabitants per year	6	?
Ratio of admissions out of total casualties & injuries (in %)	14%	?
Ratio of A&E admissions out of total admissions (in %)	43%	?

[1] Saint Jude Hospital was not in a position to provide data on new and follow-up outpatient visits. A ratio for Victoria Hospital was estimated at 70 per cent for new cases out of all outpatients and emergency visits. The same ratio was applied to Saint Jude Hospital for comparison purposes. Data for new outpatients are provided in-between brackets. [2] An assumption is made for all laboratory tests done on outpatients - on new cases only. This is only an hypothesis that needs to be verified in future. [3] An assumption of the crude birth rate at 23 per 1'000 is made based on 1996 demographic data.

The following observations are made to explain the above figures: Saint Jude Hospital recorded 682 outpatient visits/1000 population, 193 emergency room visits/1000 population, 70.2 admissions/1000 population, average length of stay 4.2 days, 19 operations/1000 population. These figures can be further differentiated e.g. in terms of type of admissions (Ob/Gyn, paediatric, surgical or medical) or class of operation (minor, intermediate and major). The government Special Task Force has studied the possibility of using an overall ALOS of 4.2 days.

A further breakdown would allow better costing and budgeting estimates for the universal health care system. However, in view of data limitations at this critical stage for setting up the universal health care system global averages may be more appropriate until further analysis is possible.

Illustrative calculations are provided in table A3.3.

Table A3.3. Indicative preliminary calculation of capitation rate

St Jude Hospital	Cases per 1'000	Units per case	Unit cost (EC$)	Cost per category of services per 1'000 (EC$)
Outpatient care	682		118	80'476
Emergency room care	193		151	29'143
Inpatient care [a]	87	4	290	105'966
Operations	19		1'068	20'292
Total cost				235'877
Cost *per capita* (capitation)				236
Capitation payment to Hospital for 57'000 registered persons				13'444'989

Victoria Hospital	Cases per 1'000	Units per case	Unit cost (EC$)	Cost per category of services per 1'000 (EC$)
Outpatient care	377		155	58'435
Emergency room care	237		142	33'654
Inpatient care [b]	81	4	290	98'658
Operations	18		1'090	19'838
Total cost				210'585
Cost *per capita* (capitation)				211
Capitation payment to Hospital for 104'000 registered persons				21'900'840

[a] Using the average length of stay for Victoria Hospital. [b] Using the per diem cost of Saint Jude Hospital and the average length of stay for Victoria Hospital.