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Commonwealth of the Bahamas

Report to the Government
Ministry of Health and National Insurance

Technical and analytical review of the proposal for a National Health Insurance programme

Social Security Department
International Labour Organization
Geneva, July 2006

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Executive Summary

(a) The Mission Request

This Report is prepared in response to a request made by the Ministry of Health and National Insurance of the Government of the Commonwealth of the Bahamas to the Social Security Department of the International Labour Office, Geneva. The Government is presently considering the introduction of a National (social) Health Insurance (NHI) scheme, and has commissioned relevant studies of both qualitative and quantitative issues. Further advice is sought to clarify certain aspects of those studies, specifically in relation to those described in the Report on Components, Costs and Financing of the National Health Insurance dated September 2005, with the objective of enabling the Government better to assess the financial viability and sustainability of the proposed scheme.

The health care services presently available to Bahamians certainly compare favourably with those available elsewhere in the Caribbean, reflecting *inter alia* the economic advance of the country in recent years. However, concerns have been expressed over quite a long period - since the early 1980s - as to the adequacy and sustainability of services on the current basis of financing, and the question as to whether access to services can be ensured *on an equitable basis* in the long term for all (legal) residents has been recognised as one which demands reassessment.

In August 2002 the Government therefore instituted a Blue Ribbon Commission, under the chairmanship of Dr. M. Perry Gomez; the Commission reported in January 2004, setting out its conclusion that the health care financing needs of the Bahamas should be addressed by the creation of an NHI scheme, within a framework of 8 specific principles (see below).

In order to provide a more detailed NHI concept, and to estimate certain crucial parameters, including in particular the expected rate of contributions to be paid by members and (where appropriate) their employers, technical studies have been commissioned under the auspices of a Steering Committee on National Health Insurance, again under the chairmanship of Dr. Perry Gomez which sent its report to the Prime Minister in September 2005. Although its report is complete in itself, the technical team formed for this purpose continues to work intensively on the details of the NHI and to develop – as far as is possible until definitive approval for the scheme is given by the Cabinet – the overall plan for the implementation of the scheme.

The work of both the Blue Ribbon Commission and of the subsequent technical studies have utilized technical advice and guidance provided through several international agencies, notably the World Health Organization (WHO) and Pan American Health Organization (PAHO). It is in line with the recommendations of the WHO/PAHO Consultant, and in the light of the long familiarity of the International Labour Organization (ILO) with the social security system in the country, that, firstly, members of the technical team undertook training in aspects of social health insurance at the ILO's International Training Centre in Turin, and secondly that the present consultancy was conceived.

The purpose of the present consultancy is, accordingly, to confirm that the technical studies undertaken under the auspices of the Steering Committee properly reflect the vision of the Blue Ribbon Commission, and that the Government and Cabinet may therefore have confidence in the contribution rates determined by the calculations of the technical study team.

(b) Objective of the Assignment

The objective of the assignment may be interpreted, broadly, as to make available relevant observations and (limited) analysis which will address the need of the Minister and his advisers to assess the soundness and financial viability of the NHI proposal, to the extent necessary that the Minister is able in good conscience to request formally that the Prime Minister and Cabinet should mandate the implementation of the NHI scheme on the basis of the parameters (including in particular the proposed contribution rate) developed by the Technical Team under the NHI Project Steering Committee.

In the view of the Consultant, the Minister and Advisers need, in this context, to satisfy themselves as regards a number of different aspects of the proposals, of which the following are critical:

- that the financial basis on which the NHI will start (assumed to be in 2007 or 2008) provides prospectively for sufficient funds by way of annual contributions to meet the properly-estimated gross annual running cost of the scheme; and
- that the continued operation of the NHI in succeeding years, in the absence of any alteration of the proposed contribution rate or other major financial parameters, will not lead to insolvency of the NHI or significant resort to open-ended support by the Treasury.

(c) Principal Conclusions

With regard to the first of these considerations, in the opinion of the Consultant, from an actuarial perspective and to the extent to which it has been possible within the scope of this assignment to assess the estimates set out in the Technical Annex to the Steering Committee report:

- these have been properly made by the Technical team, with the caveat (already known to the Technical Team) that adjustments stand to be made – but are not likely to disturb significantly the overall funding plan for the NHI - to allow for a more detailed assessment of emergency transport costs by way of "ambulance" provision, to allow for a more suitable basis of contribution by elderly members of the proposed scheme, and to allow properly for the incidence of costs of medical care for children, whether they are to be considered insured under their parents' membership entitlements, or funded by direct government contributions;
- the utilisation rates for each item of health care service assumed in the estimates are well within the ranges assumed for actuarial assessments which may be deemed reasonably comparable with the proposed Bahamas NHI scheme;
- the unit cost estimates appear to have been made on appropriate bases, and
- the estimates, including the proposed contribution rate, represent a sound basis for starting the operation of the proposed NHI.

With regard to the second major consideration, it is the opinion of the Consultant that it will be possible to operate the scheme for the foreseeable future on a basis which is financially sound and which should not require large changes to the major parameters, including in particular the basic contribution rate. This opinion is, however, subject to the qualification that, beyond the next two to three years, it is simply not possible to make a very accurate assessment of the actual year by year surplus or deficit to be expected, mainly because the fluctuations of financial conditions are essentially random, or quasi-random, and incapable of exact forecasting. The notion that the inherent unpredictability of the financial conditions results in estimations of the year-by-year out-turns of entities

broadly of the NHI (or other social security) type which are more "variable" (in a statistical sense) in years 3/4/5, and more variable still even further into the future, has been called "the expanding funnel of doubt".[1] One aspect of variability which can be foreseen with relative clarity is the ageing of the population, which in the longer term will result in a pattern of costs of health care such that the cost of the benefit "package" must eventually be expected to equate to a significantly higher contribution rate than the initial rate selected of 5.3 per cent of earnings. In general, however, the aspect of variability is inescapable, but must be *managed*. In other words, the continued viability of the proposed NHI scheme after being inaugurated will depend on management which – while dealing sympathetically with the needs of members at times of illness – must be rigorous as regards matters such as compliance with membership obligations and insistence on payment for medical services in NHI facilities by those who fail to join and contribute.

[1] See Redington, F.M.: Review of the Principles of Life-Office [actuarial] Valuations, Journal of the Institute of Actuaries (London), Volume 78.

1. Introduction

The introduction of a National (social) Health Insurance (NHI) scheme for the Bahamas has been under discussion for a number of years, and the Government has commissioned relevant studies of both qualitative and quantitative issues. A Blue Ribbon Commission was instituted and presented its report in January 2004; this was followed by a Steering Committee which reported in September 2005. The latter report was supported by the work of a Technical Team, formed for this purpose, but which continues to develop – as far as is possible until definitive approval for the scheme is given by the Cabinet – the overall plan for the implementation of the scheme. In order to confirm that the technical studies undertaken under the auspices of the Steering Committee properly reflect the vision of the Blue Ribbon Commission, and that the Government and Cabinet may therefore have confidence in the contribution rates determined by the calculations of the technical study team, the Government, through the Ministry of Health and National Insurance, requested that the ILO undertake, within a fairly limited scope, an Analytical and Technical Review.

The Director General of the ILO assigned Mr. John Woodall, Senior Specialist in Social Security of the Social Security Department of the ILO in Geneva, to carry out the review. The full Terms of Reference for the assignment are reproduced in Annex 2.

Mr. Woodall spent the period of 7 to 12 May 2006 in Nassau, working closely with the technical team, under the leadership of Dr. Stanley Lalta. Following the compilation of a draft version of his Report, Mr. Woodall returned to Nassau for the period 11 to 14 July 2006, in order to present his conclusions and facilitate discussions amongst the Minister and senior members of staff of the Ministry and the National Insurance Board.

Warm appreciation is due for the collaboration freely provided by Dr. Lalta and his team, and for the wider assistance provided by all those interviewed, in particular by the staff of the Ministry of Health under the guidance of the Minister, Sen. Hon. Dr. Bernard Nottage and the Permanent Secretary, Mrs. Elma Garraway.

Valuable liaison was facilitated through the Ministry of Labour, and thanks are due accordingly to the Minister, the Hon. Shane Gibson, and the Director of Labour, Mr. Harcourt V. Brown.

2. The NHI Proposal

2.1 In broad terms, proposals that some form of social health insurance should be developed for the Bahamas have been under discussion for over 20 years.

2.2 While the Bahamas have achieved rapid economic development in recent years, reaching an average level of GDP per capita equivalent to around US$ 17,000 per year, the fruits of that development have been spread rather unevenly, and pockets of poverty certainly remain, to some extent amongst the citizens of the Bahamas themselves, but also amongst the rather large number of migrants from neighbouring Caribbean countries, many of whom remain in the country albeit that their residence has not been legally regularised.

2.3 The population of the Bahamas is now estimated to number around 320,000, but their health needs are greatly skewed by the geographical disposition of this island country. Although some 20 or so of the islands are populated, almost 2 in 3 people live in or around Nassau on New Providence island, with another 15 per cent on Grand Bahama island, while some communities on the so-called "Family Islands" may number as few as 80 persons. Family and community links remain strong, and in case of high-cost health needs, individuals are often supported by family, friends and neighbours by way of "cook out" and similar fund-raising initiatives.

2.4 The close proximity of the Bahamas to the United States has evidently had a strong influence on the apparent health care preferences of the citizens/residents, and there is a strong tradition of seeking care from private providers, who naturally practise for profit, albeit that many practitioners, in their turn, routinely provide free or partially paid treatment to poor or indigent patients. Such patients, at least in Nassau and Grand Bahama, are also able, in general, to obtain treatment at the public hospitals, and the relatively strong economic situation of the country has enabled the Bahamas to maintain provision for the poor on this basis with relatively little difficulty until now. There appears to be little constraint to the provision of services in terms of hospital facilities (sufficiency of beds) or human resources (number of qualified medical practitioners), although, as a result of the relatively small total population of the country, certain facilities and procedures may be lacking; this deficit is partly compensated by the ability in many cases to send those needing investigations or treatment to either the United States (Miami) or Cuba (Havana).

In the Family Islands, the government has developed a network of clinics, equipped to provide services of varying levels of sophistication, but the element of "choice" in care facilities, which appears to be prized by the residents of New Providence and Grand Bahama, is hardly available.

2.5 The overall picture which emerges is (as pointed out in fact by the Blue Ribbon Commission in its report) one in which strong elements of a private, profit-oriented system of health care modelled on that of the United States blend with those derived from a tradition of public welfare-oriented care, drawing its inspiration much more from the historical influence of Britain specifically and Europe generally. The NHI proposal seeks - for well-argued reasons - to maintain both of these elements, and, although it is clearly not within the scope of the present assessment to analyse in depth the consequences of that decision, it seems pertinent to comment that these elements may not, in all cases, sit very comfortably together.

2.6 Notwithstanding, the necessary estimates of financial parameters have been developed, and the institutional development plan is progressing steadily, and taken together provide what is now a fairly detailed picture of a scheme which promises

adequate (but not excessive) funding of the general health care system for the Bahamas, greater transparency and stability of financing, and, significantly, enhanced equity of access for all, whether or not financially well-off.

2.7 The proposal does not seek in itself to mobilise a significant (or indeed any) increase in the near future in the overall proportion of the national GDP spent on health care. However, the proposal would redistribute a proportion of the obligations to meet the overall costs of the national programme of health care between the various stakeholders. In particular, it is expected that, whereas at present a significant proportion of health financing in the Bahamas is managed by means of health insurance plans transacted by several institutions including 6 local authorised insurance companies and a number of trade unions, once the NHI scheme is in place, the coverage of most direct health risks would be replaced by the national scheme of *social* insurance embraced by NHI. The rôle of private insurance would change quite sharply, to focus on coverage of, in particular, "top up" financing for private treatment exceeding "standard" needs or in premium facilities (possibly overseas), and financial coverage to enable subscribers during hospital stays to enjoy premium standard "hotel" facilities. The nature and technicalities of insurance arrangements of any kind tend not to be well-understood by the woman or man "in the street", and the next section of this report offers a few comments intended to highlight the most crucial features of the insurance process as it will apply under the NHI proposal.

2.8 In view of the Consultant's affiliation to the International Labour Office (ILO), it is appropriate to note the approach of the Office and in particular the Social Security Department, to work in the sphere of social health insurance. Because any scheme of social health insurance necessarily combines financial and health care service issues in a rather complex manner, the preferred approach is one of teamwork, to integrate the contributions of, at least, a financing (often actuarial) expert and of a health policy specialist. For the purposes of the present exercise, the need expressed by the Ministry has been to focus more closely on the financial assessment, and therefore to request the assignment of the actuarial consultant. If, however, further inputs to the development of the NHI are found to be appropriate in the future, the Office stands ready to provide such wider range of expertise, possibly in relation to several aspects of the scheme for which consultancy inputs are envisaged and terms of reference have been drafted, such as legislative development or macro-economic contextualization.

2.9 The work of the ILO - which is, uniquely amongst the technical agencies of the United Nations system, a standard-setting body – is based fundamentally on social rights. The International Labour Conventions developed and monitored by the ILO do in fact offer a legal framework for the development of national schemes of health care provision as one (of nine) of the branches of social security provision. Member countries of the ILO are of course encouraged to ratify and put into practice as many as possible of the Conventions; however, even where ratification is not possible for any reason, each Convention still provides a guide and framework for the development of national programmes which conform as far as possible to international best practice.

Two Conventions, amongst those which are current, are of particular relevance here, albeit that neither has been ratified by the Bahamas;[2] these are:

- The Social Security (Minimum Standards) Convention, 1952 (No. 102), and
- The Medical Care and Sickness Benefits Convention, 1969 (No. 130).

Convention No. 102 embodies the general and fundamental principles of social security, defining and setting minimum standards for the 9 generally-recognized social security branches. It thus provides a broad outline for a comprehensive national social security scheme covering all 9 such branches, for which provision may be made under social insurance, or complemented by programmes of social assistance. Convention No. 130 offers a more detailed outline, envisaging higher standards, in relation specifically to medical care and sickness benefits. Both Conventions envisage that in general health care will be afforded to residents (particularly workers and their families) of each country, and not only to citizens.

The proposals for the NHI appear to conform fairly well to the principles of care and coverage set out in both C.102 and C.130, although both conventions envisage that general practitioner care would be provided on both an outpatient and a domiciliary basis (NHI will generally provide only the former), and C.130 envisages the provision within the national social security scheme of dental care.

[2] The Bahamas has ratified the following ILO social security Conventions:
Workmen's Compensation (Agriculture) Convention, 1921 (No. 12);
Workmen's Compensation (Accidents) Convention, 1925 (No. 17);
Equality of Treatment (Accident Compensation) Convention, 1925 (No. 19);
Workmen's Compensation (Occupational Diseases) Convention (Revised), 1934 (No. 42);
Maternity Protection Convention (Revised), 1952 (No. 103).

3. The Insurance basis of the NHI Proposal

3.1 In the broadest terms, insurance is a means of managing certain categories of "risks". This term in itself tends to be poorly-understood, in part because a variety of different *kinds* of risks may stand to be addressed within a single set of circumstances. For example, the proposed NHI will deal functionally with the *risks faced by its members of suffering ill-health*, but will institutionally also face risks, of a different kind, to its own operations, though for example funding imbalances in the face of possible price inflation or the occurrence of an epidemic disease such as avian 'flu, or in the longer term future the possible risk of loss of political support.

In recent years increasing attention has been paid to the application of techniques of risk management in the social sphere, and a good deal of interesting literature has been published by, for example, the World Bank on the subject of "social risk management". The concept of "insurable risks" is more specific, and has been found over many years (over a century since the first origins of social insurance in Germany) to provide a very effective vehicle to address a certain range of social needs – those which are categorised generally within the scope of "social security", and which include not only the (financial) needs arising from ill-health, but also income support to individuals and families in the case of death, old-age, sickness, accident, unemployment and maternity.

3.2 The basic insurance principle is that a group of individuals facing a certain type of risk (accidental damage to a motor vehicle, fire damage to a house, loss of life, etc) may agree to "pool" their individual risks, each contributing to a fund out of which the few who actually suffer loss in any year may receive financial compensation according to an agreed formula or rules. It should be clear that while "scientific" insurance is possible in relation to many risks, certain conditions must be fulfilled, including the availability of statistics which reflect the patterns of risk and so enable the funding requirements to be estimated in advance with reasonable accuracy, and a number of participants in the pool which is much greater than the expected number of claimants. In addition, an insurance arrangement is sustainable *only if* it is perceived generally by its own members to operate in a way which is equitable or "fair".

3.3 The best-known insurance arrangements in most countries are those which are "sold" to individual policy-holders by commercial or quasi-commercial (sometimes state-owned) insurance companies. The aspect of fairness to each policyholder is ensured by calculating a so-called "premium" which reflects the actual level of risk which the individual concerned adds to the risk-pool (for example, in the case of motor insurance, the owner of an expensive car will be charged a higher premium than the owner of a smaller, older vehicle, or in the case of life insurance, the premium will be related to the age and sex of the policyholder). Amongst other features it may be noted that, because an individual's premium theoretically matches his or her risk contribution to the pool, the pool should not be unbalanced in case any individual chooses to join or leave at any time. This basis of fairness or equity is technically called the "principle of mutuality". [3]

[3] See, *for example*, Wilkie, A.D. (1997). Mutuality and solidarity: assessing risks and sharing losses. Philosophical Transactions of the Royal Society B, 352, 1039-1044, and (with discussion) British Actuarial Journal, 3, 985-996 and 1044-1058.

3.4 A social insurance arrangement differs, in particular in the basis on which individuals are required to contribute to the pooled fund. Usually this is established on a basis which is found to be socially fair or equitable, such as a uniform percentage of each individual's monthly wage or salary. The contributions should nevertheless be calculated in such a way that the total of expected claims can be paid from the pooled fund, although in some cases it may be necessary to seek sharing of the contributions not only by workers and employers, but with some subsidy from, for example, the government Treasury. The payment by each individual to the fund is not, therefore, based on an individual risk-assessment, and is not, therefore, a "premium" in the same sense as for an individual or commercial insurance. For this reason, it is helpful to avoid the use of the term "premium" in relation to social insurance schemes, using instead the simple expression "contribution". The basis of equity/fairness underlying a social insurance scheme is called the "principle of solidarity"; it is in fact different from the principle of mutuality and establishes a qualitative distinction between "commercial" (and similar) insurances and social insurances. [4]

3.5 It should be understood that *all* insurance arrangements *necessarily* have an aspect of *redistribution.* At the least, redistribution takes place to the "unlucky", i.e. those who suffer loss or illness and are therefore entitled to claim, *from* the "lucky" who suffer no loss, illness etc and make no claim. A scheme of social insurance implies an additional element of redistribution, through the social basis of allocation of contribution obligations. In the particular and rather unusual circumstances of the Bahamas, it seems that the redistributive principle may not be well understood, mainly by reason of the historical rejection of any form of progressive income taxation. Nevertheless, in relation to health insurance, special considerations apply, in that average (claim) costs per insured person cannot be related in any actuarial manner to income levels, with the result that poor individuals cannot afford the general level of premiums and are effectively excluded, to a large degree, by private risk-rated insurance arrangements. Genuine equity across income levels can therefore be achieved only in the context of a *social insurance* scheme.

3.6 The approach to the sharing of the costs of social security provision through social security is reinforced by the ILO's Convention No. 102, which prescribes [5] that , *"if a social security scheme is not financed by taxation, the cost of the benefits and the cost of the administration of such benefits shall be borne collectively by way of insurance contributions and in a manner which avoids hardship to persons of small means and takes into account the economic situation of the respective country and the protected persons."*

3.7 The NHI design may properly be described as a scheme of social insurance, but it may be noted that the quantum of contributions to be collected (from workers and employers) is not linked very tightly to the benefits to be provided in exchange, with the result that the degree to which the insurance principle is reflected in the scheme will be in some sense weakened. The design has been made in this way deliberately and for valid reasons (i.e to recognize the government's commitment to certain specific areas of provision, such as medical care for indigent persons, to stabilize the

[4] So – called "group insurances" arranged by employers for their workers may, however, have characteristics of both types: the arrangement between an individual worker and his employer is in effect one of social insurance, while that between the employer and an insurance company is usually a risk-rated policy.

[5] C.102, Article 71, paragraph 1.

financial input to the overall health care effort in the country, and to enable the level of contributions at the outset to be set at an appropriate level), and it is *not* suggested here that any change should now be made. However, this design decision does have some "knock-on" effects, and it may be worthwhile that two of these be mentioned here:

- The fact that the insurance principle – the paying of all claims from the pooled fund built from the contributions – is reflected to a degree of less than 100 per cent may have played a role in some at least of the misunderstandings and criticisms which have been levelled at the conceptual basis of the NHI proposal;
- The fact that the contribution rate for NHI is established "exogenously", and not by some form of actuarially-based or related assessment, means that periodical reassessment of the contribution rate cannot be used (directly at least) as a signal of pressures building within the relevant systems and which would indicate the need for periodical adjustment to the balance of contributions and benefits;[6] at the political level there will therefore remain a long-term need for sensitivity to any expression of will amongst the population that a greater proportion of national income be devoted to health care.

3.8 In summary, social insurance offers:

- an effective framework for health provision;
- optimum equity (or "fairness");
- potentially efficient management;

3.9 In order for the proposed scheme of social insurance to operate effectively, a number of crucial requirements need to be observed, including:

- an efficient, accurate and timely system of statistical information and its processing, to underpin the management and ongoing financial assessment systems of NHI;
- effective management of the scheme, in a very broad sense, which will include the responsibilities of not only administrative and clerical staff as such, but also the responsibilities of medical staff as regards, for example, specialist referrals and prescription of drugs;
- safeguards against the "standard" operational risks facing insurance arrangements, including moral hazard, asymmetric information use, etc.

3.10 It appears that, presently and in broad terms, between one quarter and one third of health financing in the Bahamas passes through the health insurance plans of the 6 private insurance companies active in this market. The figure of $102.3 million is quoted, as relating to the year 2001, in both the report of the Blue Ribbon

[6] As may be seen, rather dramatically, in relation to the contribution rate needed for the operations of the National Insurance Board (NIB). The latest actuarial calculation of the required contribution rate for the currently-specified benefits has indicated the need within the next few years for a sharp increase. While this has caused some alarm, and incidentally focused sharp attention on administrative costs, the actuarial assessment of the contribution rate has in a fundamental manner fulfilled its proper purpose of signalling the inescapable need for rebalancing of benefits and contributions within the NIB.

Commission [7] and the Technical Annex to the report of the Steering Committee on NHI, [8] and is understood to refer to premiums paid. [9] The Blue Ribbon Commission report goes on to provide figures from the Registrar of Insurance Companies, which appear more or less compatible, and which show (for the year 2001) premium receipts by the local private insurance companies of $87.6 million and claims paid of about $42.1 million. It is understood that these figures are not strictly comparable as between themselves, owing to incomplete returns to the insurance registrar's office and resultant deficiencies in the compilation of statistics. Nevertheless, there are indications that the overall "claims ratio" may be relatively low. There is neither enough information available to the Consultant to conduct a more detailed analysis, nor is that within the scope of this assessment. However, it is clear that the insurance companies must seek both profitability and to meet fairly heavy administrative costs in this insurance branch, and it seems likely that several tens of millions of dollars paid annually by insured individuals to the insurers must be absorbed in the insurance arrangement and therefore *never* becoming available for actual health care services. [10] This is in addition to the costs absorbed directly by administration within the public health system. There should certainly be an opportunity, essentially through realising the benefits of scale, for the social insurance proposed under NHI (in addition to its equity advantage) to improve considerably on the administrative efficiency offered by the private insurance arrangements presently complementing the public health care system.

[7] See Blue Ribbon Commission report, page 71.

[8] See Steering Committee report, Technical Annex 1.6.2.

[9] It appears that the annual returns made by insurance companies to the Registrar may not have been made on a very consistently timely basis, leading to some difficulty in distinguishing and comparing "premiums received" and "claims paid".

[10] In addition to the insurance companies' legitimate claims on some percentage of the premiums paid, to meet administration costs and provide profits, there may also be unseen factors, including requirements to write moneys to technical reserves or external reinsurance arrangements, which cannot be analysed properly without much more extensive information and analysis.

4. Technical Elements and Assessment

4.1 In this section, comments are offered in relation to relevant aspects of the reports prepared by the Blue Ribbon Commission and under the auspices of the Steering Committee (in particular, in the Technical Annex appended thereto).

(a) The Principles Laid Down in the Blue Ribbon Commission Report

4.2 Recommendation No.1: NHI should be universal

4.3 Recommendation No.2: NHI legislation should be enacted

4.4 Recommendation No.3: NHI should be administered by the National Insurance Board (NIB)

4.5 Recommendation No.4: NHI should offer a "comprehensive" benefits package

4.6 Recommendation No.5: Contributions should be set at a rate which is affordable for the majority of the population

4.7 Recommendation No.6: Public and private providers should be offered the opportunity to join the NHI system

4.8 Recommendation No.7: All provider payment mechanisms should be considered for use, with capitation being the preferred option

4.9 Recommendation No.8: A percentage of revenues should be set aside for purposes that ensure the stability and sustainability of the NHI system.

4.10 These principles are, in the opinion of the Consultant, appropriate both separately and collectively. Care may be needed to ensure that, in relation to Recommendation No. 3, the capacity of NIB to administer the scheme can be matched to the needs of the scheme (which will include a very much greater emphasis on claims administration than hitherto), and that, in relation to Recommendation No. 4, false expectations are avoided as to the meaning of a "comprehensive" benefit package.

(b) The Key Assumptions Made During Costing and Financing Calculations (section 2.3 of the Steering Committee report of September 2005)

4.11 (a) All calculations are based on projected 2005 costing and utilisation data

Comment

This basis is appropriate; to the extent that it has been possible to check the estimates against (actuarial or similar) assessments for other countries, the utilisation rates are well within expected ranges. In order to provide some degree of specificity in this regard, consideration has been given to the single component of the NHI "package" which is estimated to be the most expensive, namely short-stay in-patient care. In comparison to a "comparator" scheme of social health insurance currently under actuarial analysis in the Social Security Department of the ILO, the per capita utilization rate, measured as number of days per insured person per year, for the NHI

estimates, is within approximately 20 per cent of the figure experienced in each of the last 5 years for the working-age insured members of the comparator scheme.

4.12 (b) Every working person will be required to contribute to NHI

Comment

Ensuring compliance in this respect will require strong management and effective sanctions; consideration should be given to the means by which each of these may be put in place.

4.13 (c) NHI will not pay for the cost of care for those who are not paid-up members.

Comment

The level of rigour required of management in this regard is similar to that noted in the previous comment. It will be important that proper annual auditing of NHI is commissioned and the results publicised; in particular it is critical that "bad debts" are not allowed to accumulate, and that appropriate sanctions are available to ensure a high level of repayment of such debts.

4.14 (d) The insurable wage ceiling for assessment of NHI contributions will be set at $5,000 per month

Comment

It is envisaged that this ceiling figure will not be fixed in nominal (dollar) terms, but is to be adjusted annually in proportion to earnings, so as to maintain its value in "real" terms and the general proportionality of financial elements of NHI. The estimates have been carried out on a basis which assumes that the relevant adjustments to the earnings ceiling will be made without (any) delay each year, and this basis is appropriate for the estimates, noting that in practice some time at least will be needed for calculating and implementing the annual adjustment. The adjustment must be made effectively automatic, and cannot wait for the passage of supplementary legislation through parliament each year. It is understood that no satisfactory basis for indexation (against wages or salaries, rather than prices) exists at present, in which case mechanisms must be put in place from the outset for NHI's own statistical system to maintain records of members' gross earnings (in addition to the assessable, "capped" figure) so as to generate the average (gross) earnings figure from NHI's own resources each year.

It is noted that the proposed wage ceiling proposed for the outset of the NHI scheme does not correspond to that prevailing for the existing major social security scheme in the country. While the level chosen for NHI is appropriate in itself, in the longer term it would be desirable, for reasons of administrative simplicity and general understanding of the schemes, to seek as far as possible to harmonize the two figures.

4.15 (e) Pensioners will contribute at the rate of $1 per day.

Comment

This proposal has already been returned to the technical team for reconsideration. It is considered that in equity, pensioners should pay some level of contribution to the scheme, probably at a rate set as a percentage of (pension) income. The annual quantum of contributions estimated from pensioners at the outset under the original assumption is, however, around $8 million, in an expected non-government

contribution total payable by workers, employers and pensioners of $124 million. The impact on the financial estimates of the contribution basis is, therefore quite limited (as regards the early years of the scheme), and the choice of the contribution rate may be set on social, as much as financial, considerations. In particular, care should be taken that no individual is likely to find the dollar amount of her/his contributions to be higher after retirement than before. The expectation that pensioners should contribute is by no means unknown in other national schemes, one example being the scheme in Germany, to which pensioners pay a percentage of their income. The social health insurance scheme for the (worldwide) staff members of the ILO, which is designed essentially to substitute for national scheme provisions, also requires contributions, albeit at "flat" monthly rates, from its members.

4.16 (f) Employers and employees will share contributions equally

Comment

This is appropriate (and in conformity with ILO principles)

4.17 (g) Government will pay contributions for "indigent" members

Comment

This is appropriate.

4.18 (h) Government will continue to fund costs at the MoH, DPH and Public Health and Public Hospitals Authorities related to administration and essential public health functions.

Comment

This is appropriate.

4.19 (i) Government will continue to finance and provide direct medical care associated with "public health"

Comment

This is appropriate.

4.20 (j) Government will continue to finance long-term care at STC through current mechanisms

Comment

This is appropriate, although it would be worthwhile to check that possible overlaps with NHI will not complicate management on this basis.

4.21 (k) Government will allocate $18 million for capital expenditures

Comment

This is appropriate, although it will be necessary to check the need for long-term expenditures at higher rates (if for example full scale development of a new hospital is called for), and the implications whether such expenditure in the government sector must be financed directly or through debt servicing.

4.22 (l) Government will impose (and collect) non-subsidised user fees for non-members of NHI

Comment

This item is closely related to assumptions (b) and (particularly) (c). See comments under paragraphs 4.12 and 4.13 above.

4.23 (m) Total government financing of healthcare should remain at current levels

Comment

This is appropriate as the basis for estimation of the financing mechanism at the outset, and reflects explicit indications as to the expected policy of government for the foreseeable future. However, it must be anticipated that the pattern of demand will change, however gradually, as the inevitable ageing of the country's population proceeds. In the longer term (say 15 to 20 years), it will fall to the government to consider the degree to which a greater proportion of national resources need be devoted to the health needs of an increasingly-elderly population. Since the NHI does not incorporate a mechanism for automatic increase of contributions, there is no inherent "signal" to enable government, potentially, to respond to such changing demands and preferences for health care (in relation to other expenditure opportunities or needs) and the relevant trends must be monitored explicitly (see also comment under paragraph 3.6 above).

4.24 (n) Cost of administration and reserves should not exceed 5 % of the cost of benefits.

Comment

This assumption may be viewed in the following perspective.

The estimates imply that the first-year claims under NHI will be approximately as follows:

- primary care consultations 812,000 visits
- specialist consultations 209,000 visits
- A&E 90,000 visits
- Home care 105,000 visits
- In patient long-term (mental health) 1,000 admissions
- In-patient short-term 25,000 admissions
- "Catastrophic" events 1,000 – 1,500 cases

In addition, diagnostic facilities and pharmaceuticals are provided, but are likely in the great majority of cases to be included with claims of the types listed above.

Thus the estimated number of claims per year may be approximately 1.25 million.

Within the proposed administration budget, it may be possible to employ around 50 claims administrators with appropriate skill levels (possibly by retraining existing NIB administrators, or perhaps claims administrators redeployed from the private insurance companies) at a possible cost per capita of between $60,000 and $100,000 (inclusive of salaries and overhead costs). Each must therefore handle an average of

25,000 claims per year, which would equate to about 100 per day or 15 to 20 per hour.

It is anticipated that a high degree of computerisation and automation will be put in place, and this issue forms part of the brief of the technical team. However, it must also be expected that a proportion of claims will be complex or difficult to resolve. The conclusion is that, while not totally unrealistic, the provision of adequate claims handling capacity within the proposed administration cost envelope is a demanding assumption.

4.25 (o) The costing estimates are based on the utilisation rates set out in Table 13 of the Technical Annex to the report of the Steering Committee.

Comment

This is appropriate, See also comment under assumption (a) paragraph 4.11 above.

4.26 (p) Provider agreements will include contracts with local providers, etc.

Comment

This is in conformity with the general design assumptions for the NHI scheme, but highlights the urgent need for rapid implementation of an effective, in-house statistical and data management system – see comments under assumption (d), paragraph 4.14 above, and also paragraph 6.1 below.

5. Overall Assessment – Feasibility and Sustainability

5.1 The Minister and Advisors need, and the purpose of the Consultant is to provide relevant perspectives in this regard, to satisfy themselves as regards a number of different aspects of the proposals, of which the following are critical:

- that the financial basis on which the NHI will start (assumed to be in 2007 or 2008) provides prospectively for sufficient funds by way of annual contributions to meet the properly-estimated gross annual running cost of the scheme; and
- that the continued operation of the NHI in succeeding years, in the absence of any alteration of the proposed contribution rate or other major financial parameters, will not lead to insolvency of the NHI or significant resort to open-ended support by the Treasury.

5.2 With regard to the initial feasibility, in the opinion of the Consultant, from an actuarial perspective and to the extent to which it has been possible within the scope of this assignment to assess the estimates set out in the Technical Annex to the Steering Committee report:

- these have been properly made by the Technical team, with the caveats (already known to the Technical Team) that adjustments stand to be made – but are not likely to disturb significantly the overall funding plan for the NHI - to allow for a more detailed assessment of emergency transport costs by way of "ambulance" provision, to allow for a more suitable basis of contribution by elderly members of the proposed scheme beyond pensionable age, and to allow properly for the incidence of costs of medical care for children, whether they are to be considered insured under their parents' membership entitlements, or funded by direct government contributions;
- the basis for estimating the participation of "indigent" persons, for whom contributions would be paid by the government, are somewhat uncertain, and although unlikely to impact the design on the basis of the calculations made by the technical team, must be monitored closely through the NHI's own statistical systems once the scheme is implemented;
- the utilisation rates for each item of health care service assumed in the estimates are well within the ranges assumed for actuarial assessments which may be deemed reasonably comparable with the proposed Bahamas NHI scheme;
- the unit cost estimates appear to have been made on appropriate bases, and
- the calculations, on a "best estimate" basis, including the proposed contribution rate, represent a sound basis for starting the operation of the proposed NHI.

5.3 With regard to sustainability, it is the opinion of the Consultant that it will be possible to operate the scheme for the foreseeable future on a basis which is financially sound and which should not require large changes to the major parameters, including in particular the basic contribution rate. This opinion is, however, subject to the qualification that, beyond the next two to three years, it is simply not possible to make a very accurate assessment of the actual year by year surplus or deficit to be expected, mainly because the fluctuations of financial conditions are, essentially random, or quasi-random, and incapable of exact forecasting. The notion that the inherent unpredictability of the financial conditions results in estimations of the year-by-year out-turns of entities broadly of the NHI (or other social security) type which are more "variable" (in a statistical sense) in years 3 and onwards, and more variable still even further into the future, has been called

"the expanding funnel of doubt".[11] The variability is inescapable, but must be *managed*. In other words, the continued viability of the proposed NHI scheme after being inaugurated will depend on management which must be uncompromising as regards matters such as compliance with membership obligations and insistence on payment for medical services in NHI facilities by those who fail to join and contribute. Given the nature of the needs in the field of health care, management must nevertheless deal sympathetically with members of the scheme and promptly with all reasonable claims.

5.4 One aspect of future variability which can be foreseen with *relative* clarity is the ageing of the country's population, which will inevitably have an impact on the pattern of demand for health care, and its cost in the longer term. An important aspect of the NHI design is the affordability of contributions paid by and on behalf of the members, and does not require that such contributions should cover *in full* the cost of the package of benefits provided to them (the proposed initial rate of 5.3 per cent of earnings does not in fact do so, although the "gap" is relatively small). However, comparison with schemes in countries in which the ageing process is more fully advanced indicates that the cost of a comprehensive benefit package will eventually rise to a level which equates to a contribution rate significantly higher than this initial figure.

5.5 From the perspective of overall management, the relevant tools for cost management may be grouped as:

- cost control;
- demand control;
- contribution adjustment.

In addition, there will be an aspect of management which amounts to responsiveness to a "normal" range of "business risks", including inflation and the need to minimize the incidence of moral hazard.

5.6 The doctors providing care under the NHI will have important responsibilities in relation to cost control, to ensure the proper management and utilisation of resources (particularly financial) under the scheme. This means that, for example, referral procedures and pharmaceutical prescription practices must be efficient and carefully worked out before the scheme is inaugurated. (See also comment at 6.3 below).

5.7 On the other hand, demand control should be supported by, in particular, a programme of sustained and continuing public education. Fears are expressed that the provision of benefits to newly insured persons is likely to be followed by over-claiming, perhaps massively, under NHI. Although it will be natural for individuals at the outset to "explore" their rights under NHI and the degree to which it meets their needs, it seems likely that – with appropriate guidance from, in particular, the medical professionals as to the disbenefits, rather than benefits, of over-medication and over-treatment – this should be a problem limited to the very short-term.

[11] See Redington, F.M.: Review of the Principles of Life-Office [actuarial] Valuations, Journal of the Institute of Actuaries (London), Volume 78.

6. Further Observations

6.1 Although the technical study team working under the auspices of the Steering Committee has utilized data wherever possible from established institutional sources, together with well-established methods of estimation, significant parts of the data have been derived on an ad hoc basis, in the sense that they can – obviously – not reflect actual practice and experience once the NHI becomes operational. It is critically important that adequate data and statistical systems be instituted on an "in house" basis from the inception of NHI, and utilised to manage the financing of the NHI in accordance with its own actual periodical utilisation and cost experience.

6.2 Care needs to be taken whenever officials share in public their perceptions as to the development of NHI. It appears that comments have been offered to reassure the public as to the "comprehensive" nature of the health care to be offered under the scheme; in the context of the Blue Ribbon Commission and Steering Committee reports, it is evident that this term is intended to have a specific and rather limited meaning, i.e. that care will be offered under all of the categories of out patient consultation, specialist consultation (on the basis of referral), short –term and (some) long-term in-patient admission, pharmaceuticals and diagnostic provisions. "Comprehensive" care is not intended to mean, as might be assumed by the public, that every conceivable medical procedure will be supported by NHI. The potential for misunderstanding – and unfortunate inflation of public expectations – is clear, and it may be helpful to prepare a briefing note on this and other items of technical terminology for the use of officials likely to be engaged in presenting or explaining the scheme in public. However, it is envisaged that a specific consultancy will be undertaken to crystallize the concept of "comprehensiveness" for NHI purposes.

6.3 From the standpoint of professional ethics, in the context of his/her relationship with a patient a doctor would be expected to hold paramount the interests of that patient. It is likely that the continuance of present approaches to this issue will lead to some difficulties under NHI – if, for example, the doctor wishes to recommend referral of a patient to private rather publicly-practising consultants or prescribe branded rather than generic medications. It is suggested that this issue needs to be discussed in advance (once the implementation of NHI has been confirmed) with the medical profession, from the standpoint that a degree of balance will be needed between:

- their professional responsibilities to patients *individually*; and
- their professional responsibilities to patients/members of the NHI *collectively*.

6.4 In broader terms, it may be said every participant in the NHI, including the individual insured members, will have responsibilities to engage with the scheme in an appropriate way, both as contributor and as claimant. The sense of "ownership" of the scheme by its members is therefore of great importance, and ways should be sought, without undermining the day-to-day professional management of the scheme, to ensure appropriate representation of all "stakeholders", including the insured members, in the general supervision of the NHI.

6.5 It is envisaged that a number of contextual issues facing the NHI in its implementation phase will be addressed by way of specific consultancies, some of which are mentioned in previous sections of this report. The full benefit of the social insurance vehicle for health care financing depends needs to be realized through the *integration* of the financial and care aspects of health provision. The ILO would welcome further opportunity to participate with the Ministry and NIB to work towards the optimal outcome of the NHI proposal.

Annex 1. List of Principal Contacts

Ministry of Health and National Insurance	
Sen.Hon Dr. Bernard Nottage	Minister
Ms. Elma Garraway	Permanent Secretary
Ms. Elizabeth Keju	Under Secretary
Dr. Merceline Dahl-Regis	Chief Medical Officer
Dr. M. Perry Gomez	NHI Implementation Project Director
National Insurance Board	
Mr. Lennox McCartney	Director
Mr. Derek Osborne	Consultant Actuary
NHI Implementation Project	
Dr. Stanley Lalta	Project Manager, NHI Implementation Project
Ms. Étoile Pinder	NHI Implementation Project Team
Ms. Zaneta Adderley	NHI Implementation Project Team
Public Hospitals Authority	
Mrs. Hannah Gray	Deputy Managing Director
Ms. Lisa Recketts-Hall	Statistical/Information Officer
Ministry of Finance	
Ms. Ruth R. Millar	Financial Secretary
Mr. Simon Wilson	Director of Economic Planning
Ministry of Labour	
The Hon Shane Gibson	Minister of Immigration, Labour & Training
Mr. Harcourt V. Brown	Director of Labour
Medical Association of the Bahamas	
Dr. Horizal Simmons	
Dr. Robin Roberts	
Dr. Duane Sands	

Annex 2. Terms of Reference for the Consultancy
(February 2006)

1. Background

In 2002, Cabinet established the Blue Ribbon Commission to evaluate the capacity of the health system to respond to current and projected health needs and to propose financing options for meeting the costs of the required health services. The Commission's Report was presented to Cabinet in January 2004. It recommended the establishment of a National Health Insurance (NHI) Plan as the most feasible financing instrument for generating adequate revenue and ensuring equity in access to health services.

In terms of the design of an appropriate NHI Plan for The Bahamas, the Commission Recommended 8 guiding principles:--

- Universal coverage.
- Mandated membership.
- Administration of Plan by the National Insurance Board.
- Comprehensive benefits package.
- Revenue generation through affordable contributions.
- Public and private providers to form the service provider network.
- Mix of provider payment methods with capitation being preferred.
- Contingency fund for stability and sustainability.

Cabinet accepted the recommendations of the Commission and appointed a Steering

Committee in mid-2004 to undertake the preparatory work and detailed financial analyses for implementation of an NHI Plan. This Report on the Components, Costs and Financing of NHI (September, 2005) responds to a specific request from Cabinet for estimates of the cost and funding options for an NHI with particular reference to coverage of a comprehensive benefits package. It was presented to Cabinet in January 2006. Cabinet accepted the Report in principle and mandate, an independent evaluation of the methods, assumptions and findings.

2. Specific Tasks of Consultant

The consultant will be required to conduct a financial and economic appraisal of the estimates and recommendations in the Report on Components, Costs and Financing of NHI (September, 2005). He/she will also be required to present a full Report on findings to the Ministry of Health and to discuss the findings at a meeting of senior officials.

The appraisal should include the following activities:

- review of the baseline data used in the estimates of costs and financing;
- assessment of the estimation approaches and methods bearing in mind standard international practices;

- examination of the assumptions made in the Report and-the likely impact on the estimates of alternative assumptions;
- assessment of the validity, consistency and implications of the findings;
- specification of gaps in and other concerns over the Report;
- suggestion of other data sources, methods and comparative experiences which may be appropriate in addressing the gaps and concerns;
- discussion and clarification of data, findings and any other concerns with members of the NHI Technical Team and other health and finance officials;
- presentation of findings and recommendations of evaluation at meeting of senior health and finance officials.

3. Expected Outputs

The consultant is expected to present a report - and summary Powerpoint notes – that contains the results of the appraisal including specific suggestions for revisions and alternative analytical frameworks that may be helpful.

4. Level of Effort Required

All tasks in the consultancy should be completed within 12 days. (See schedule below).

Activity

1.	Review of Report and Technical Annex (in advance)	3 days
2.	Meeting with NHI Technical Team to discuss and clarify estimates, assumptions and conclusions	2 days
3.	Meeting with health, finance and NIB officials to discuss and identify issues, concerns and implications of findings	2 days
4.	Preparation of Report and presentation	2 days
5.	Presentation of Report at meeting of senior officials	1 day
6.	Travel to and from Nassau	2 days