



NATIONAL HEALTH INSURANCE RESPONSE TO:

**“Health Insurance in The Bahamas –
An Analysis of the Blue Ribbon Commission’s Proposals and an
Examination of Alternative Policy Options”**

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NATIONAL HEALTH INSURANCE IMPLEMENTATION PROJECT

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NATIONAL HEALTH INSURANCE RESPONSE TO THE REPORT BY THE NASSAU INSTITUTE SEPTEMBER 18TH, 2006

1. General Comments:

The 72-page Report 'Health Insurance in The Bahamas: An Analysis of the Blue Ribbon Commission's Proposals and an Examination of Alternative Policy Options' (July 2006) sought to review, and offer alternatives to, the proposals for National Health Insurance (NHI) in The Bahamas with particular reference to the experiences and evidence on health financing in developed countries.

We welcome the intent and content of the Report. We found it to be quite incisive and comprehensive as it blends empirical data, theoretical constructs and policy models in its analysis of the NHI proposals.

The Report presents several findings some of which are true and some of which are new. However, often those which are true are not new and those which are new are not true.

The Report is quite strong in its focus on some experiences and evidence while choosing to exclude others that may have been less convenient. This selectivity has been quite useful, as it has encouraged a re-examination of some NHI proposals as well as re-enforcement of others.

The various comments and inferences on 'cost' throughout the document suggest that the opportunity cost of health spending is too high for The Bahamas; that the country cannot afford an aging population (which, it suggests, will be expanded because of NHI) and that a minimally-regulated competitive health market is needed to control cost by determining the mix of services, levels of spending and access to care.

The balancing 'benefit-investment' approach to health spending by countries and business enterprises (WHO, 2001) as well as by individuals (Grossman, 1999) which treats good health as a national and individual resource with intrinsic and instrumental value seems to have been systematically ignored in the Report.

In general, the Report's recommendations seem to rely more on theoretical and ideological notions of the 'efficiency' of competitive markets in health that bear little relation to the evidence even of that in developed countries which it describes as having 'successful health care models'.

The Report cautions that implementing the NHI proposals verbatim would create a ‘substandard healthcare program whose cost far exceeded what was necessary...’ for The Bahamas. Quite emphatically, The Bahamas should be even more worried and alarmed if it chose to implement the recommendations of the Nassau Institute Report verbatim.

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A. Executive Summary (p.4-6)	Detailed responses to matters in the Executive Summary are presented in the Chapter reviews.
p.4.par.1: Experience and evidence from the world’s most developed nations should ultimately guide NHI development in Bahamas.	Health and health financing systems in developed countries provide information, approaches and suggestions. They do not exhaust the possibilities for new design and there is no clear reason why they should ‘ultimately guide’ NHI development. Relevant experiences of developing countries e.g. Costa Rica, Chile, Malta, Bermuda, Barbados are also considered as we seek to design an appropriate plan that meets the current and future needs of The Bahamas.
p.4.par.3: Age-adjusted health spending shows The Bahamas has high costs, good access but average quality outcomes.	<p>This is a useful approach and it provides clues on where to target action. However, this approach needs to bear in mind the other factors which lead to high costs such as scaling services and technologies for our small population (Re: ‘technological indivisibilities’); inefficiencies in the public sector and charges by private health providers which are more closely linked to charges for services in the USA (while our GDP per capita is less than 50% of the US).</p> <p>In addition, international data suggest we should broaden our analysis of cost drivers since aging is just one of several factors that determine patterns of utilisation and health expenditure (Barer, 1987; Mossialos and LeGrand, 1999; Zweifel, Felder and Meirs, 1999; Culyer and Newhouse, 2000; Jonsson and Eckerlund, 2003; OECD, 2006).</p>
p.4.par.4: The BRC proposals, if implemented verbatim, would create a substandard health care program whose cost would far exceed what was necessary to deliver the level of quality care.	<p>The BRC proposals are not cast in stone and are being subjected to further analysis, review and modifications for implementability.</p> <p>The definition of ‘necessary’ varies according to the beholder and over time. It is not clear how the reviewer determined what is the ‘necessary’ cost or the ‘level of quality care’ for The Bahamas given the similarity of illness conditions and other health challenges with developed countries.</p>

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p.4.par.5: BRC's call for equal access is flawed because it will prohibit or restrict private care.

This is a misinterpretation of the proposals for universal and equal access. NHI fully recognizes the importance of the private sector and has no proposal that interferes with patients exercising their right to choose their provider of care.

p.5.par.1: BRC proposals cover emergency care and treatment of communicable conditions for illegal migrants. This will encourage greater migration.

BRC proposals cover care for humanitarian and public health protection reasons. This is critical no matter what type of health plan is in place or the legal status of residents.

However, it should be noted that that illegal migrants (and short-term visitors) will not be eligible for membership in NHI but will have access to care in public and private facilities. Their health bills will have to be met using their own resources. For those unable to pay, a separate allocation will have to be made from the government's budget. NHI resources will only be used to pay for NHI members.

It should be recalled that illegal migrants move to particular countries for many other reasons than access to health care. If access to health care were the primary motivating factor, how does one account for so many migrants going to the USA than to Cuba.

p.5.par.2: The BRC benefit package is as generous as those in developed countries. This is costly and unsustainable since health expenditures could grow faster than the economy as in developed countries.

The logic of this criticism by the reviewer is that, with NHI, public and private providers will be 'doing too much' in terms of health services for the population.

There are few developed countries which consider their benefit packages as 'generous'. Most confine the package to 'medically necessary' services that respond to the broad spectrum of health needs in the population.

The Bahamas' disease burden is fairly similar to that of developed countries. Since the treatments and technologies for caring are also similar, it is expected that some costs will necessarily be high whether there is NHI or not.

These costs have to be met either collectively or individually. An NHI shares the costs among all persons with the ability to contribute so that the burden is light for each. If, with a less 'generous' package, the burden of care is shifted largely to individuals - many of whom cannot manage their health bills - then the extent of financial protection in our health financing arrangements is weak.(Murray and Evans, 2003).

Before seeking to ascribe blame to an NHI plan for 'unsustainable' future health costs, it

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would be useful to examine those health costs that are inevitable from those which are avoidable (Blomqvist and Carter, 1997; Barros, 1998; Gerdtham and Jonsson, 2000; OECD, 2006). In this context, one can reasonably ask - is there any evidence to show that countries with NHI or publicly financed health systems have faster and more unsustainable rates of growth of health costs than those without?

p.5.par.4: The NHI contribution will have an impact not dissimilar to a tax on individuals and employers. This would lead to lower take-home earnings, business slowdown and reduced economic growth and progress.

Using this logic, it would appear that a compulsory pension plan would also be considered as a tax. So too would be the premium deduction for a negotiated group health private insurance plan.

In most countries, employers and workers share the NHI contribution and treat it as an essential part of lifelong 'social security' investment rather than a tax (Glaser, 1991; Roemer, 1993; Saltman, Busse and Figueras, 2004, Carrin and James, 2004).

Lest we forget, business decisions are made in a dynamic, not static environment and an NHI contribution is one of several factors that are considered in making these decisions.

The experience in other countries – including those cited as successful in the report (Japan, France, Singapore, Australia, Switzerland, Sweden) show that, with NHI or other compulsory contributions, businesses and individuals make adjustments - in wages, prices and spending over time. Is there any evidence that, because of their NHI or publicly financed health plans, some countries had slower growth rates in the economy, employment and earnings or overall socio-economic progress (growth with equity) than other countries?

p.5.par.5: Aging of population will lead to increasing cost and burden on the young and working population.

It may be recalled that health professionals—public and private—generally regard increasing healthy life expectancy in the population (i.e. 'adding years to life and life to years' for all) as a good outcome of their efforts rather than as a 'cost' and 'burden' to society.

The key point is that aging of the population and added cost of caring would happen whether there is an NHI or not in The Bahamas. The only other remedy is to stop people from getting old—maybe the reviewer can suggest how we and every other country can do that (!)

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Additionally, if the objective is to reduce or avoid any burden on the ‘young and working’ population, should we require the elderly and children to pay all or a substantial portion of their health bills? This is not the norm in the successful developed countries cited by the reviewer.

So it is quite unclear why this normal phenomenon of aging and the established practice of ‘intergenerational transfers’ for meeting the health bills of the elderly should be posited as obstacles in developing an NHI plan for The Bahamas.

It should be noted that the NHI, recognizing the need for sharing of costs across all groups with the ability to pay and the expected growth in the elderly population, has clear proposals for contributions by pensioners.

p.5.par.6: BRC’s proposed capitation payment system is not in keeping with best practice. Fee for service (prospective) and DRGs are preferred.

NHI will examine these and other payment systems to find the most appropriate. It should be noted that prospective fee for service and DRGs are used extensively in the US health system and there are volumes of rules, regulations and court cases that attest to the difficulties and abuse experienced in these payment systems. (Ellis and McGurie, 1986; Dranove, 1988; Scheffler, 1998; Culyer and Newhouse, 2000; World Bank, 1997; WHO, 2003).

p.6.par.6: NIB will be high cost inefficient administrator. So leave NHI to private insurers.

While there is public data on the administrative costs of NIB and the measures being implemented to reduce these costs, there is no matching information on local private insurers. Given international data on their risk selection approach and administrative costs, assuming ‘efficiency’ because insurers are ‘private’ may be a leap of faith where the management of NHI is concerned (Stone, 1993; Jacobs, 1996; Chollet and Lewis, 1997; Woolhandler, Campbell and Himmelstein, 2003; Mossialos and Thompson, 2004).

It should also be noted that, in terms of practicality, NIB already has a wider network of offices as well as systems and staff for several of the tasks in managing a national plan than any private company. However, NIB’s role as manager does not rule out other private sector involvement, and we are actively considering relations with private firms for claims processing and management of overseas referrals.

p.6: Recommendations of Report

More comments are provided on the recommendations in Section 5.

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> privatize hospitals, clinics, other health activities for more efficiency.

Neither the literature cited by the reviewer nor the experiences of the developed world's successful healthcare models support such privatization. Even in Switzerland there is a mix of public and private health facilities.

Additionally, privatization assumes that 'efficiency' is the only objective of the health system. If this were so, will 'efficient' private owners/providers change their current mode and location of operations to provide regular services to those in the Family Islands? (At present, the data suggest that about 25% of the population live in the Family Islands but the majority of their care is provided in public facilities rather than by private operators).

Will they give priority in treatment to 'productive' persons while delaying or denying treatment to some persons such as the elderly (who have 'passed their peak earning years' as stated in the Report —p.29), disabled and children because of efficiency and profit considerations?

> Other health activities should be subject to competitive bidding

In principle, this is a good approach since 'competition **for** a market' can have similar or even more beneficial effects than 'competition **in** a market'.

Competitive bidding assumes that there is a large number of capable suppliers of services. While this is true for internationally sourced items and supplies e.g. drugs, medical supplies and technology, it is questionable whether the same exists with respect to suppliers of local services.

> Accreditation of health facilities should be done by a third party.

This is in keeping with 'best practice' and is already being examined by the Ministry of Health and relevant heads of health facilities.

> Hospitals should be paid by prospective fee for service or case payment.

Given the mixed experience with prospective fee for service and case payments (Donaldson and Gerard, 1993; Jacobs, 1996; Kutzin, Barnum and Saxenian, 1997; Hofmarcher and Durand-Zaleski, 2004), these along with other payment mechanisms are being examined to determine the most appropriate mix of mechanisms for use in the NHI plan.

> Physicians should be paid by prospective fee for service.

As in the above recommendation on payment to hospitals, the pros, cons and practical application of various payment mechanisms are being examined to find the most appropriate system of payments.

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> Patients should share in cost of care with exemptions for the poor

There are several good reasons for cost-sharing and it is already being examined to determine how to optimize its effectiveness in NHI.

> NHI should be administered by public and private insurers who can offer flexible plans.

This is worth considering in some detail. There are 2 major options which are likely — firstly, legislated NHI with competing insurers as administrators; secondly, legislated NHI with competitive bidding among insurers to select one for management of the plan (i.e. ‘administrative services only’ plan).

Internationally, the experience with competing insurers and multiple payers as against a single insurer-payer has been mixed. Reviews show that in countries like Chile and Colombia and even in some developed countries private insurers continue to ‘cream-skim’ members while dumping ‘sub-standard’ and ‘uninsurable’ persons on the public insurers (Stone, 1993; van de Ven and Ellis, 2000; Dror, 2000; WHO, 2003; Docteur and Oxley, 2003; Saltman et. al, 2004, Anderson and Hussey, 2004; Greb, 2006).

Competing public and private insurers in a compulsory health plan require extensive regulations to cover enrolment, services, contributions, appeals, co-payments and mechanisms for risk equalization transfers.

In addition, while flexible health insurance packages allow for more choice, the need for some standardized packages is critical to avoid insurers offering minimal packages that cover very few health bills while shifting the large bills to individuals or to the public system.

The second option involves competitive bidding for administration of the plan. This is attractive because of the benefit of competition and innovativeness. On the other hand, there are major concerns in respect of the willingness of insurers to make heavy investments for administration of a national plan knowing that in a year or two depending on the period of the contract, one could lose out to another insurer with a repetition of the contract uncertainty.

In a small country (population—320,000) a single administrator may be more feasible and efficient rather than having several segmented risk pools. Private companies can offer supplementary and other flexible plans while the core package is covered by the NHI.

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The NHI proposal seeks to avoid the likely difficulties with these 2 ‘competitive’ options in assigning responsibility for administration to the NIB.

(As a side note on this recommendation in the Report—if Bahamians are required to purchase insurance by law then compulsory contributions will have to be made to competing public and private insurers. In its critique of the NHI proposals, such a compulsory contribution was seen as a ‘tax’ on employers and workers with all the associated negative impact on wages, profits and the economy. Does it mean that it is no longer a ‘tax’ because the same contribution will be managed by competing insurers?).

> A parallel private health sector must exist with minimum regulations.

There is no proposal in the BRC’s Report which threatens the existence of the private health sector. In fact, the private sector may be strengthened and expanded as a result of NHI. However, even the most successful countries have extensive regulations to govern the establishment, operations and accountability of private providers.

NHI proposals have provisions for the activities of private insurers. In fact, with NHI covering the bulk of health bills in its standard package, private insurers may be better able to target specific services and market segments for expanded coverage.

It is unclear what the report terms ‘minimum regulations’. In every developed country there are necessary sometimes extensive regulations to govern the operations of the private health sector. Why should The Bahamas ignore this evidence in its provisions for the private health sector?

It should be noted that NHI, in view of economies of scale considerations, is already considering a role for the private sector in providing some specific services on an ‘exclusive’ or ‘non-competitive’ basis. This is based on the fact that it may not be economically feasible to have more than one centre of excellence for some high technology services, given our small population size.

B. Introduction (p.7)

There is a wealth of evidence on health plans in developed countries. This

The BRC, in its research, reviewed much of the evidence/experience of health financing plans in developed and developing countries. The NHI team is committed to knowledge-

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evidence should be the ultimate guide for The Bahamas.

based proposals and welcomes any new evidence offered in the Report. This evidence will be subjected to the same rigorous analysis as was done in previous reviews rather than casually assuming that the evidence in the Report is the only data that merits consideration.

C. Section 1. The Health Care System and Population Health(p.8-9)

p.8.par.2: Government should simply focus on ensuring access to basic health care, ensure the poor have access and require citizens to have catastrophic care cover.

Since the definition of ‘basic’ and ‘catastrophic’ varies among countries, over time, and among income groups, it is unclear what is being proposed in this statement.

What should be done with ‘non-basic and non-catastrophic’ care? Or are there only 2 categories of health services?

Also, while the reviewer wants us to follow the evidence from developed countries, this evidence shows that the government-public sector is actively involved in providing and financing a range of health services (Roemer, 1993; WHO, 2000; Saltman et.al, 2004; PAHO, 2004). So, should we follow this evidence or the reviewer’s recommendation?

p.8-9: Discussion on Adverse selection

The reviewer presents a good discussion on adverse selection but only very limited evidence to arrive at the conclusion that community risk pooling should be left to the market/profit maximising private insurers. (See also Rothschild and Stiglitz, 1976; Evans, 1984; Stone, 1993; Chollet and Lewis, 1997; Dror, 2000).

Despite the ‘conclusive’ evidence claimed by the reviewer, many governments in developed countries have legislated compulsory community rated health insurance to counter adverse selection (Saltman, Busse and Figueras, 2004; Carrin and James, 2004). Are these governments guilty of ignoring the ‘evidence’?

p.9.par4: The existence of problems with the market is not enough reason to support government intervention in health...

Using this same logic, the mere existence of problems with government intervention is not enough reason for privatization or letting the market determine who gets health care or who manages the plans (Donaldson and Gerard, 1993; Dror, 2000, Culyer and Newhouse, 2000).

***D. Section 2. The Bahamas’
Health Care System (p.10—17)***

p.10—11: Age adjusted costing-expenditure data on health care in The Bahamas show that costs are very high (even when compared to developed countries) and outcomes are average.

It is helpful to know that The Bahamas is being compared to the most developed countries in the world with significantly more resources and long-established health systems!

The findings on age-adjusted health spending provide valuable information for further analysis and action.

It should be borne in mind that age is a useful indicator but a poor predictor of health expenditure from year to year. The OECD Economic Affairs Department in a recent paper (2004) on what drives cost of health services pointed out that growth in incomes and technology acquisition are more powerful than age in driving health costs.

This is in line with other economic and actuarial analyses which sought to show the relation between age and health services utilisation and found a significant but relatively low impact (Dunn et. al, 1996; van de Ven et. al, 2003; Greb, 2006)

In addition, health costs are driven by inefficiencies in the delivery of health services as well as by pricing-charging practices of health professionals. The reviewer will find that age-adjusted health spending will also show high costs in similar-placed countries such as Bermuda, Cayman Islands, Turks and Caicos Islands where private health professionals and insurers are heavily influenced by rates and charges in the US health care market.

There are 2 further aspects to consider in the comparative data on age-health costs relation. Firstly, why should we assume that developed countries are spending the ‘right’ amount on health?

Secondly, is there a linear relation between age and spending so that if the percentage of our elderly population is one-half that of a developed country, our health spending should also be one-half?

p.11—13: Access is good in The Bahamas in terms of health facilities, health professionals, beds, use of

One of the key reasons for this is the sustained commitment by successive governments and private professionals to health care. Over the last 2 decades health spending has accounted for about 15% of the government’s budget (the second highest allocation after

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medical technology.

education).

p.13—17: Quality is variable but less than average.

The relatively weak performance reflected in some of the indicators used to measure quality such as infant and child mortality rates is already well-known to local health professionals. The necessary action is being taken.

Other new measures discussed by the reviewer such as ‘Mortality Amenable to Health Care’ rely on incompletely specified relationships and data. Even the reviewer admitted in some places that some of the summary statistics ‘do not measure the true underlying chances...’ and can only be used to give a ‘rough approximation.’

E. Section 3. BRC Proposals (p.18- 40)

In general, the reviewer’s comments in this section remind one of the ‘straw man’ argument. He sets out in many places what the BRC proposals are not, knocks those down and then claims the proposals are flawed.

p.18-19.par.3: misinterpretation of the terms equal access, equity, and universal coverage.

This is the first ‘straw man’. The reviewer (deliberately) misconstrues the BRC proposal on ‘equal access’ to refer to prohibition of private care and private insurers and ‘monopolisation’ by NHI. After a long discussion, he later he admits (p.19, par.4) that ‘the evidence supports the BRC’s statement that private health insurance should continue to allow Bahamians to access health care in their discretion’.

p.20.par.1-2: Distribution of health facilities is sensible for technical and economic reasons. Bahamians must either abandon the term equal or carefully define it to ensure that health care investment is not guided by political desire but by economic and technical realities.

While there is general agreement on this comment about the current distribution of health facilities, the particulars suggest (and should suggest in the future) the incorporation of other factors such as ‘geographical equity’ in the location and distribution of facilities.

In addition, given the volume of planned developments in the Family Islands (International Monetary Fund, 2006), it is expected that the range of health facilities in the Family Islands will need to be reviewed and modified.

According to the evidence, developed countries also recognize that economic and technical reasons alone are not enough in decisions on the establishment of health facilities (Evans, 1984 and 2002; Donaldson and Gerard, 1993; Barr, 1998).

p.20-21: Care to illegal migrants

As indicated earlier, illegal migrants go to particular countries for a mix of reasons and

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access to health care may be very lowly placed in making their choices. NHI will only pay the health bills of its members and illegal migrants will have access to care but will be required to their own bills.

p.21: Recommendation on legislated NHI. Regulation of private health insurance is an ill-advised policy.

This is a strange recommendation since even in the US which has a well-developed and entrenched private market for health there are several volumes of laws and regulations on private insurance (as for banks and other financial and commercial enterprises).

The same or perhaps higher levels of regulation exist in relation to private health insurance in European Union countries (Mossialos and Thompson, 2004). Does it mean that all these countries are following an 'ill-advised policy'?

The alternatives to regulation are 'no regulation' and 'self-regulation'. It may be quite difficult to find any developed country which uses these alternatives in relation to private health insurance.

p.21-23: Administration of NHI by NIB is convenient but inefficient compared to private insurers

The assumption that competing private insurers (multiple payers) are more efficient than a single-payer is rather tenuous. The international data on the cost of administration by private insurers as against single public insurers suggest that the former are not as efficient as the reviewer claims they are. Mossailos and Thompson (2004) cites data from European countries which show that administrative costs of private insurers range from 10% - 30% while among public insurers the range was 5% - 10% . (See also Glaser, 1991; Evans, 2002; Scheffler, 1998; Saltman, Busse and Figueras, 2004).

In The Bahamas, while the data on administrative cost of NIB is public knowledge, that of private health insurers is not generally available. In the absence of evidence on the efficiency of local private insurers, one can only deduce that this statement is more one of conjecture than of fact.

p. 23-27: BRC's recommendation of a comprehensive benefit package is too generous and will be too costly.

Our comments on the issues relating to the 'generosity' of the benefit package are dealt with on p.2 in regards to the Executive Summary of the report.

The reviewer also makes several suggestions on rationing, gatekeeper roles and co-payments to manage costs. These are already being considered in the continuing work on an implementation plan for the BRC's proposals.

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p.27-30: The contribution rate will be a tax on economic activity and will affect profits, investment, take-home earning and restrict the labour marketplace.

Data on the taxes in developed countries indicate that in the majority of these countries the tax burden ranges from 30-50% of GDP (IMF International Financial Statistics, 2004). In The Bahamas the tax burden is less than 20%.

More specifically, all the evidence and best practices from the successful developed countries cited in the report—Japan, Australia, Singapore, France and Switzerland—show major contributions from employers and workers for health.

In Japan, it is about 10% for NHI shared equally; France about 14% with 13% paid by employers; Singapore about 12%--16% shared almost equally. Australia has a largely tax-funded health system (with income, indirect, capital gains and other taxes) requiring payments by employers and workers.

So, we can logically ask—did these contributions or ‘taxes’ deter the economic progress of these countries? Even if we claim that The Bahamas is different, let’s compare with similarly-structured countries like Bermuda and Cayman Islands which are service-based economies (largely, tourism and financial services).

The Bermuda compulsory hospital services only insurance plan in place since 1971 requires about 4% of earnings shared equally (with government paying for children and the elderly). And Cayman Islands comprehensive package health insurance requires about 7% of earnings shared equally.

It would also appear that these compulsory health plans did not reduce business confidence, investment, employment and overall economic activity in these countries.

Overall, the evidence on countries with NHI and other tax-funded health systems suggests that businesses and workers adjust to compulsory health (and other) deductions in different ways and over different time periods. In fact, the pattern of economic growth and development in these countries may have been enhanced, not hindered, by these compulsory deductions.

p.29: On NHI, aging and affordability of contributions

The reviewer warns that NHI, by providing access to medical services for the elderly, will ‘help Bahamians live longer at the margin’ needing expensive care and being burdensome to the working population. Does this mean that we should not have an NHI because it will

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foster aging or we should stop persons getting old because they become ‘expensive’?
It would be very helpful if the reviewer provided some data on how ‘efficient’ and ‘competitive’ private insurers address these affordability concerns in respect of aging.

p.29: NHI, the Bahamian economy and sustainability.

Using data from a particular source (World Bank, 2005), the reviewer indicated slow or negative growth in the economy. However, alternative sources (International Monetary Fund, 2006) suggest that the economy actually grew slightly in 2001 by 0.8% rather than declined by 3.5% as stated by the reviewer. Also, the average annual inflation adjusted GDP per capita over the period 1995—2002 was about 2.2% not 1.1% (Department of Statistics).

Projections for 2005 and 2006 suggest that real GDP per capita would continue to grow by 2.7% and 4.0% respectively (International Monetary Fund, 2006).

p.30: NHI, the ‘practice of medicine’ and future cost of NHI

The reviewer’s refers to the high levels of utilisation, intensive use of technology and high costs of a specific public insurance program for the elderly (Medicare) in the US and infers that NHI will have similar future effects.

The point is that many of these changes are currently taking place and will increase without an NHI. NHI takes these concerns on board in its estimates so that future utilisation, technology and costs may be better managed in line with future growth in income and the economy.

p.30-39: Service Providers and Payment Systems

> p.30.par. 4: While the BRC’s desire for private provision of services is not based on economic and international evidence, it does ultimately reflect best practice.

On the contrary, the BRC had adequate data at its disposal (local and international) in its making the proposal for full inclusion of private health professionals and facilities in the provider network.

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> p.31-36: Fee for service vs. capitation vs. salary as payment mechanisms for physicians

While the discussion and data presented has been quite educational, it would appear that there is still much diversity of opinion and inconclusiveness in respect of payment forms and the likelihood of supplier induced demand (Donaldson and Gerard, 1993; Kutzin et.al., 1997; Chollet and Lewis, 1997; Mossialos and LeGrand, 1999; Docteur and Oxley, 2003). This makes the reviewer's summary statement that fee for service should be the preferred payment system as rather suspect and it fits too neatly into some preconceived position.

p.36-40: Paying for Hospital Services

While making the case for DRGs, the reviewer should also bear in mind the likelihood and reality of DRGs leading to fraud and abuse (RE; cases of 'DRG creep' and 'unbundling' and 'cream skimming' of patients in the US health insurance system).

As in the case of fee for service payments to private providers (above), the experience of abuse and cost escalation in the US Health system led to extensive regulations, monitoring arrangements and the institutionalisation of 'managed care' to curb the excesses of the 'competitive' market (World Bank, 1997; Docteur and Oxley, 2003).

p.39-40: NHI reserves and funds for health enhancement activities

It is quite strange that the NHI proposals to encourage 'wellness' and 'illness prevention' and quality improvements should be seen as 'infringing on the daily lives of Bahamians or 'expensive patches' or 'wasteful'.

The BRC proposals reflect concerns over illness and the sources of illness. This necessitates action on both fronts rather than making the NHI a strict 'sickness' insurance plan.

It should be noted that, contrary to the reviewer's advice, emphasis on wellness and illness prevention is already part of the intervention programmes provided by 'efficient' and 'innovative' private health professionals and insurance companies.

Section 4.p.41-46: Developed World's Successful Health care Models

> Australia; Japan; Singapore, Sweden, Switzerland.

It is interesting to note that the 5 success stories presented by the reviewer have universal health systems that rely heavily on compulsory contribution-based funding (Japan, Singapore, Switzerland) or tax-based funding (Australia, Sweden). In all of these countries, except Switzerland, employers contribute significantly to health financing plans. BRC's

proposals reflect many of the best practices in these countries.

***Section 5. Policy
Recommendations for The
Bahamas. (p.47—50)***

> p.47.par.1: The Bahamas might best be served by the privatization of hospitals and other health related activities and the introduction of cost-sharing for services.

In a real sense this is the major recommendation by the reviewer for an alternative approach than NHI. The rest of the recommendations that follow represent a back-handed approval of NHI but with competitive insurers at the forefront.

> Recommendations 1-8:

Our comments on these recommendations are presented in the section relating to the Executive Summary.

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