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Nassau Institute on NHI Proposal

As the Bahamas contemplates a massive move down the road of socialized medicine, it must pause and look at the state of the nationalized healthcare programs presently in place. Two appraisals merit attention.

“Sir John Templeton warns of the looming Baby Boomer crisis that is about to devastate Europe and the United States...77 million boomers are about to retire - and they will wreak havoc on Social Security, private pension systems and our health care system.”

Alan Greenspan opines, "Our country will face abrupt and painful choices unless Congress acts quickly to trim Social Security and Medicare benefits for the baby boom generation... Government resources, even under the most optimistic economic assumptions of growth and productivity, will be inadequate to provide baby boomers with the level of benefits their parents got."

Fifty years of experience was the basis of “Health Insurance in the Bahamas”, an analysis of the Blue Ribbon Commission’s proposals submitted by the Nassau Institute (the “Institute”) to Government.¹ The National Health Insurance Implementation Project (“NHI”) comment on the experience and evidence cited in this Report was “There is no clear reason why it should ‘ultimately guide’ NHI development.”² The position of the Institute is “Those who do not learn from history are condemned to repeat it”.³

The NHI project should provide its citizens with a list of those innovations in its proposal that would cause the Bahamas to avoid the looming crisis described by Sir John Templeton and Alan Greenspan.

For starters.

Minimally the NHI project cannot move forward without the Government supplying the National Coalition for Health Care Reform with the Steering Committee’s financial report on the program. One cannot approve a long-term program of this size without identifying the relevant assets and liabilities presently employed and providing a forecast of future revenues and planned expenditures. Provision of a single number for the total program cost that is

¹ Nadeem Esmail, the Fraser Institute of Canada, “Health Insurance in the Bahamas: An Analysis of the Blue Ribbon’s Commission’s Proposals and an Examination of Alternate Policy Options”, 72 pages.

² National Health Insurance Implementation Project, “NHI Response...”, September 19, 2006, page 2.

³ Bill O’Reilly, *Culture Warrior*, Broadway Books, 2006, page 193.

unrelated to actual base year data and is made without specifying the year associated with the one-number forecast is simply unacceptable.

Constructive proposals.

Furthermore, the specific recommendations of “Health Insurance in the Bahamas” Report should be considered; they are repeated here.

1. Hospitals, clinics and other health activities/services should be privatized.

Government Business Enterprises tend to be inefficient. This is a well-documented conclusion; and it is certainly true in the Bahamas. The BRC itself found the Bahamian National Insurance Board to be overstaffed by 25% and poorly managed. There is no evidence that BTC, the Airport Authority, the Post Office, etc. are better managed; and, in fact, the Government itself implicitly has recognized that it cannot manage either the water purification or the hotel businesses.

Nevertheless, it is pushing forward with its government run, highly bureaucratic proposal that will take a growing share of economic resources out of the private sector and transfer it into the public-managed sector. The Government should actively promote free market solutions where the financial markets determine the availability of capital and the consumer determines the acceptability of the service provided.

It should look at Sweden for guidance. “Seven emergency hospitals in the Stockholm region serve almost two million people. Since 1999, one of them has been privately owned: St. Goran’s Hospital, which realized a savings of 15 to 20 percent over the average of the publicly run hospitals....In 2000, two hospitals turned themselves into publicly-owned companies with formal business structures, financial statements, and a board of directors; at least two of the remaining ones had planned to do the same.”⁴

The Government, for instance, should approach the Mayo Clinic or a major U.S. Baptist or Catholic hospital and enlist their participation in a separately incorporated joint-venture. This would help remove the institution from political pressures and allow it to concentrate on its professional tasks with greater efficiency and less waste. Eventually, this should end with the Government selling its shares to the Bahamian public and recouping its investment.

2. Accreditation/certification of facilities and caregivers should be handled by a private third party.

The BRC indicated that the Ministry of Health should accredit all health care providers. This creates a serious conflict of interest since the Ministry would have a dual role as a provider of public health care and at the same time accredit and certify private health care providers. NHI Implementation Project has indicated that it is examining this issue taking into consideration “best industry practice.”

⁴ Nadeem Esmail, page 45.

3. Hospital and facility care should be funded using prospective fee-for-service, or case payment, system.

The BRC proposed that hospital and facility care providers would be reimbursed on a capitation basis where the budget allocation or grant is not directly related to the specific services rendered. Under this system there is less of an incentive “to provide a higher or superior quality of care...On the other hand, facility/hospital administrators have an incentive to discharge patients quickly, avoid admissions as a means of controlling expenditures...and to tie up bed resources with long-stay patients” who are less costly to the hospital.⁵

Nadeem Esmail proposed a “prospective fee-for-service” or “diagnostic related group (DRG)” payment system. “The idea is fairly simple: the service provider is paid a fee for each individual treated based on the expected costs of treating the diagnosis of the patient at the time of admission including any significant co-morbidities.”

NHI claims that the actual experience with DRG systems is mixed; and that such systems could lead to “fraud and abuse.” Fraud is possible under any payment scheme; but the experience with DRGs in Europe has been strongly positive with large gains in efficiency.

4. Physician care outside of hospitals should be funded fee-for-service.

“Doctors may be paid by one of three methods: salary, capitation payment (based on the number of patients registered to a doctor), or fee-for-service.” The BRC recommended that the Bahamas should move away from a fee-for-service system; whereas Nadeem Esmail favors the fee-for-service and possibly a combined salary/fee-for-service in less populated areas.

This is a complex subject and at stake is the financial viability of the NHI proposal and the Government’s ability to deliver on its promises. The Institute believes that an examination of the facts will support the DRG alternative as the “most appropriate” system of payment.

5. Patients must be required to share in the cost of NHI-funded services they consume through either co-payments or deductibles. Low income populations should be exempt from this requirement subject to a bare minimum of regulation.

If the patient does not share in the cost of the service at the time that it is used, then medical care becomes a free good and the demand for medical care skyrockets. This is the result of making healthcare a human right and a universal entitlement, a steadily expanding demand follows. Even in the U.S., demand eventually exhausts the financial resources available and painful political and bureaucratic rationing of medical services follows.

⁵ Nadeem Esmail, Bahamas Health Analysis, page 36.

This problem is implicitly recognized by the BRC in its cost containment recommendations: the creation of a drug formulary where only drugs listed by the Government are available to patients and the employment of “gatekeepers” who control access of patients to specialist treatment. The excess use of insured goods and services is well understood, it results from the incentives created by reducing the prices of goods and services reimbursed by insurance.⁶

Furthermore, high taxes to finance a national healthcare program “affect the incentives for investment, risk-taking, entrepreneurial activities, and working by reducing the value of any gains that might accrue from these activities.” In Western Europe such high cost social welfare programs have helped to produce low economic growth thus limiting the employment opportunities for all age groups.

- 6. NHI should be provided by both public and private insurance companies in a competitive marketplace. Bahamians should be required to purchase insurance by law, while those who cannot afford insurance should be given vouchers to purchase insurance from the provider of their choice. NHI insurance providers should also be permitted to offer a multitude of insurance options and not be regulated to the extent that consumer sovereignty or insurance plan flexibility is needlessly restricted.**

Both Nadeem Esmail and the Institute propose free market solutions; whereas the NHI Implementation Project stresses Government operated enterprise and/or intensely regulated private enterprise. Neither alternate is optimal. Furthermore, NHI assumes that the individual is limited in his ability to take care of his own needs and the market place will not provide the services needed. The Institute does not agree with either of these assumptions.

- 7. A private parallel health care sector must continue to exist and should be subject to a bare minimum of regulation.**

Healthcare everywhere has been subject to excessive regulation that significantly raises the cost of healthcare and thus lessens the attractiveness of this business to new entrants, investment and innovation. The key is to regulate appropriately for financial solvency, transparency and consumer protection. On the other hand, regulations like community rating, guaranteed issue and a prescribed basket of goods ultimately restrict competition.⁷

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⁶ Nadeem Esmail, page 26.

⁷ Nadeem Esmail, an e-mail commentary, October 30, 2006.