

ALTERNATIVE SOCIAL-FINANCING SCHEMES FOR THE HEALTH SERVICES IN ST. LUCIA

Carl M. Stevens */

*/ Professor of Economics, Reed College. This report has been produced pursuant to Contract No. DPE-1406-S-00-1044-00 with S&T/HEA, AID/W.

Preface

This document reports the findings of a preliminary inquiry into the feasibility of developing alternative social-financing schemes for the health services in St. Lucia. This preliminary inquiry is regarded as the first of a number of activities (steps) which collectively are required to inform the design of such schemes and, if all goes well, to lead to the implementation of them.*/ The main focus is upon developing employment-related contributory

*/ For a general statement of what is entailed by this kind of feasibility assessment, see the author's "Assessing the Feasibility of Alternative Social-Financing Schemes for the Basic Health Services in LDCs," February 1982, henceforth STEVENS/ASSESSING.

insurance schemes for those who live and work in the rural, agriculture economy.*/

*/ A rationale for this focus will be found in STEVENS/ASSESSING, cited foregoing.

Introduction

Saint Lucia, with an area of 238 square miles, is the second largest of the Windward Islands in the Eastern Caribbean. The current population is about 120,000, about 40 percent of which lives in the capital of Castries and

its suburbs. Only two of the other nine administrative districts into which the country is divided have populations of 10,000 or over (namely, Dennery and Micoud). The terrain of St. Lucia is mostly mountainous such that most of the population is located in the coastal areas.

St. Lucia had a per capita GNP equivalent to about US\$790 in 1979.*/
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*/ For this and other macroeconomic data reported in this section, see Economic Memorandum on St. Lucia, Report No. 3433-SLU, World Bank, May 18, 1981.
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After rapid economic growth averaging 10.6 percent annually between 1976-78, the growth rate slowed to about 4.0 percent in 1979. Owing to the combined impact of a number of factors (Hurricane Allen, recession in the United States, labor problems), GDP declined by about 4.6 percent in 1980. Although some 43 percent of the labor force is employed in agriculture (including forestry and fishing), this sector generated only about 14 percent of GDP in 1979, less than the 15 percent contributed by Government Services in that year. In 1979, Construction, Wholesale and Retail Trade and Hotel and Restaurants together generated about 35 percent of GDP. Manufacturing contributed about 7.0 percent and Banking and other financial services about 13 percent.

The recent economic reversals contributed to the first public sector current deficit in a number of years, about 3.0 percent of GDP in 1980/81. There has been a widening of the balance of payments current account deficit in recent years, from an equivalent of about 16 percent of GDP in 1977 to about 27 percent in 1979. However, capital inflows increased approximately in line with the growing deficit. Owing in large part to the impact of Hurricane Allen (leading to a shortfall in agriculture commodity exports),

the 1980 balance of payments current account deficit reached about 40 percent of GDP in 1980. This was financed by official and private investment inflows and some emergency reconstruction assistance.

The Health-Services Sector: Some Structural and Financing Features

The health-services sector in St. Lucia exhibits some features atypical of LDCs, e.g., the role played by expatriate contract physicians. At the same time, however, the sector conforms in its major outlines to the pattern which has become familiar in LDCs. There is a Ministry of Health system, financed out of general tax revenues, which is supposed to deliver services without user charge to the whole population. The MOH system has developed a substantial facilities infrastructure, including one major hospital (which provides most of the inpatient hospital services in St. Lucia) and a network of more than 20 Health Centres located throughout the country. However, the MOH system is severely underfinanced such that it cannot in fact comply with its charge to deliver "free" services to the population at large. Partly in consequence of this, a large and flourishing private sector operates along side the MOH system, supplying most of the outpatient services for the country. Most patients finance their demand for services from the private sector by out-of-pocket payments. In St. Lucia, as in many other LDCs, this characteristic pattern sets the context in which we seek to rationalize health-sector financing by developing alternative social-financing schemes. There follows a more detailed account of the sector.

The general tax revenues which finance the MOH system are derived from various duties, consumption taxes, license and other fees, etc. and income taxes which comprise about 20 percent of the total. Given the nature of the revenue sources including the relatively small proportion of the total raised

by income taxes (and the difficulties inherent in administering such taxes in this context), it would appear that there is little progressivity built into this system.

For 1979/80, total government recurrent expenditure (actual) is reported as \$49.6 million.*/ (All \$ figures EC\$ unless otherwise indicated. At the

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*/ The main source of information on government revenues and expenditures is the Estimates of St. Lucia, published each year (and available for a small charge from the Government Printing Office).

For any given year, say, 1981/82, Estimates exhibits, for 1980/81, Revised Estimate 1980/81 and Actual Expenditures 1979/80--i.e., there is a two-year lag in reporting Actual Expenditures. Generally, the Estimates for any given year are in excess of the subsequently reported Approved Estimates for that year and the latter appear to be in excess of the subsequently reported Actual Expenditures for that year (although I understand that this is not necessarily the case). For example, for total MOH system expenditure on recurrent account Estimate 1979/80 was \$8.6 million. The subsequently reported Actual Expenditures 1979/80 were \$6.9 million, i.e., about 80 percent of the Estimate. (I have not determined whether this particular Estimate/Actual ratio generally obtains over the years.)

Generally speaking, and in spite of the lag, it is the Actuals which are of most interest for analysis of health-sector financing. For some purposes, however, it may be necessary to rely on the Estimates, e.g., to get some idea of what the most current trends may be.

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official exchange rate, US\$1.00 = EC\$2.70. For the same year, actual recurrent expenditure by the government on medical services is reported as \$6.9 million. Thus, medical services accounted for about 14 percent of total government recurrent expenditure. The ratios for 1978/79 and 1977/78 are, respectively, about 15 percent and 13 percent. Thus, the track record over these years indicates, relative to the performance in many countries, a substantial fiscal effort on health account.*/

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*/ Generally, government expenditures on recurrent account will be of most interest for purposes of this discussion. I may note, however, that of 1981/82 Estimate total government expenditure on capital account of \$106.9

million, medical expenditure is \$9.4 million, i.e., about 9 percent. Approximately 89 percent of government capital expenditure (both total and medical) is financed by grants and loans.

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If one takes the 1979 population to be 120,000, government medical services expenditure on recurrent account amounted to about \$58 per capita in that year. (At the official exchange rate this is US\$21 per capita.)

Given the lag in reporting the Actuals, it is not possible to say what current per capita expenditure rates are. However, a rough estimate may be attempted. The 1981/82 Estimate for medical services is \$14.3 million. If one assumes that the Actuals will turn out to be 80 percent of the Estimate (see footnote p. 4), that the population growth rate is about 3 percent, and that the relevant inflation rate is about 12.5 percent/year (the GDP deflator appears to have been moving at about this rate in recent years), then the present recurrent account per capita expenditure rate would be about \$72 in 1979 dollars, i.e., a 24 percent increase in real terms over the two years. This figure should of course be construed with caution.

The percent of total government expenditure going for health services provides a measure of the "fiscal effort" on health account but not of the "economic effort," so to speak. For this latter, the ratio of expenditures on health services to GDP is required. Government expenditure on health services on recurrent account in 1979 amounted to about 1.9 percent of GDP in that year. (Total government expenditure on health services, i.e., both recurrent account and capital account, was about 2.2 percent of GDP in that year.)

As already mentioned, the private health-services sector is a very significant factor in St. Lucia. Unfortunately, on the basis of the information available, it is not possible very precisely to account for expenditures in

the private sector. Some inferences about the relative importance of the private sector can be drawn from data on the importation of medicines and pharmaceutical products. These imports have been reported for some recent years as: */

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*/ See Annual Overseas Trade of St. Lucia, Part I (various years), Department of Statistics, Ministry of Trade, Industry, & Tourism & Foreign Affairs, Government of St. Lucia.

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1978 - \$2,193,611
 1979 - \$2,368,406
 1980 - \$3,043,344

For 1979/80, actual expenditures by the MOH system for "medicines and dressings" (acct. #315:021) are reported as \$849,679 of which, it has been suggested to me, about 80 percent probably represents expenditures for medicines and pharmaceutical products. On this basis, in 1979, MOH expenditures for drugs and medicines represented only about 29 percent of the total value (CIF) of imports of these products, the remaining 71 percent being, presumably, dispensed in the private sector.*/ Owing to markups (over CIF) for

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*/ There are, of course, many different kinds of "medicines and pharmaceutical products" such that treating this category on an aggregative basis doesn't yield as informative a picture of the relative roles of the public and private sectors in the provision of drugs as could be desired, e.g.; perhaps for important (medically efficacious) drugs, the MOH system plays a larger role than would be suggested by the aggregative comparison. Published data do not permit a more detailed analysis.

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drugs dispensed in the private sector, actual expenditures for drugs in the private sector are no doubt considerably larger relative to MOH expenditures than would be suggested by the foregoing comparison. Some drugs are dis-

pensed in the private sector pursuant to physicians' prescriptions. It is my understanding that drugs are also dispensed by pharmacists without physicians' prescriptions, as they respond to customers who may seek their advice. Of the 23 pharmacists reported as in the country, 9 are reported as in the public service, 14 in the private sector.*/
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*/ See preliminary Draft of forthcoming 1981/82 Annual Report of the Ministry of Health. The pharmacist/population ratio is reported as 1:5,230. The 1979 Annual Report of the MOH reported 21 pharmacists, 12 in the private sector.
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In addition to drugs, physicians services represent another important component of health-care expenditure in the private sector, albeit on the basis of the information available it is not possible to determine how important.*/ Of the 40 or so physicians in the country (about 1 physician to
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*/ In some situations, investigators have been able to establish a "lower bound" on physicians' incomes by appealing to income tax information. Owing to the confidentiality of such tax information in St. Lucia, this approach is not possible here.
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each 3,000 population), about half are full time in public service (in the main, these are expatriate "contract officers").*/ With a few exceptions for
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*/ The number of physicians in the country varies considerably over the short run owing to the special position of St. Jude Hospital, a semi-private facility located in Vieux-Fort. Some discussion of St. Jude follows subsequently in the text.
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certain of the consultants in this group, these physicians are not supposed to engage in private practice. Of the remaining physicians, about half are

part-time in public service and do engage in private practice and about half are in full-time private practice (including those at St. Jude Hospital). Thus it would appear that a substantial proportion of total physician man-hours in St. Lucia are devoted to private practice, it being unclear, however, what expenditures for these services are.

Hospital services are also provided in the private sector. In the main, these are provided by St. Jude Hospital, a 110 bed facility leased by the government to the Sisters of the Sorrowful Mother who manage and administer this facility. Except for two full-time physicians, physicians services at St. Jude are provided by short-term visitors, the number of which may vary between none and ten or so from time to time. The government subsidizes this hospital (Estimates reports under Actual Expenditures 1979/80, a \$995,442 contribution to St. Jude (acct. 315:020 (c))). Although St. Jude charges fees for services rendered, it is run as a not-for-profit institution, i.e., it attempts just to cover costs and break even.

Victoria Hospital is the other main general hospital, a 231 bed MOH facility located in Castries. Victoria has a few private beds (the Baron Wing), but revenue from private-pay patients in Baron Wing is very small, being reported for 1979/80 as only about \$51,000. Additional general hospital facilities include two MOH District Hospitals, one at Soufriere and one at Dennery, with 53 beds between them (these beds are characterized by the MOH as "grossly underutilized"). Altogether, St. Lucia has about 3.3 general hospital beds per 1,000 population, a high ratio for an LDC. According to the preliminary Draft material for the forthcoming MOH 1981/82 Annual Report, in 1980, St. Lucia experienced about 684 hospital patient days per 1,000 population. About 27 percent of the inpatient days were provided by St. Jude.*/
Jude.*/

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*/ This kind of comparison of course gives only a very rough idea of the relative importance of the private and public general hospital sectors. Information which would help to refine the comparison would include information on discharges by diagnostic category, costs per patient day and private vs. public expenditures for services provided.

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Some additional suggestive evidence of the importance of the private medical-services sector in St. Lucia is afforded by the fact that private insurance companies here do write health insurance policies, including Group Medical Plans for employed beneficiaries (the premiums being financed by employer and employee contributions, say on a 50-50 basis). I have not undertaken a systematic survey to determine what the total volume of such insurance business is, although it has come to my attention that two carriers here provide between them Group Health Plans for about 20 companies and their employees, and there are additional carriers in the health-insurance business. A representative of an insurance carrier here with whom I discussed this matter expressed the view that health-insurance coverage was quite widespread. His company writes individual policies as well as group policies, the premiums for the former being, of course, considerably higher (by about two-thirds) than those for the latter. In spite of this, his company was doing a larger volume of business with individual coverage than with group coverage. He also pointed out that various companies provide group health plans for their employees which they self-insure, i.e., rather than contracting with a carrier.

The foregoing account goes about as far as one can on the basis of readily available information in establishing the relative significance of the private sector. Information of a general kind from various respondents in St. Lucia (physicians and others) also confirm the importance of the private

sector. As a generalization, it might be said (according to one authority) that "primary care" in St. Lucia is largely in the private sector in the sense that by far the largest part of expenditure for such care is private rather than public, whereas, for hospital care, the position is reversed. The MOH system in St. Lucia features a quite extensive infrastructure of some 24 Health Centres (with three more under construction) strategically located throughout the country. And the MOH system is supposed to provide "free" care to all. Why, then, should the private sector be so prominent? We explore the answer to this question in the next section.

Some Constraints on the MOH System

It should be remarked at the outset of this section that in St. Lucia, prior to 1979, the MOH system charged all patients (i.e., not just a few private-pay patients as now) for most services rendered, e.g., consultation, surgery, drugs. There was a low-income cut-off point such that below that income level the patient received free services and about that level the patient paid the full freight. This scheme entailed an inequity in the sense that patients with incomes barely above the cut-off point were charged as much as patients with incomes many times that level. Also, it appears that one major consequence of this system was the refusal of many patients to pay such that the MOH system was burdened with an unacceptably high rate of bad-debt expense.*/

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*/ This consideration draws attention to a frequently overlooked advantage of financing the demand for health care by insurance schemes (which entail prepayment) rather than by out-of-pocket payments. In the U.S., the "Blues" (Blue Cross and Blue Shield) were born during the years of the great depression as provider-sponsored insurance schemes intended to help cope with precisely this problem.

Any health-services delivery system which provides valuable services free of user charge (or any other system which delivers any valuable product free of user charge) is almost certain to exhibit shortages, i.e., demand in excess of supply at the prevailing price (namely, zero). Any such system may be more or less supply constrained but, in any event, almost never will it be supplied with resources (nor will the intention be to supply it with resources) sufficient to deliver all of the services the consumers want at zero price. Consequently, the output of the system will have to be somehow rationed among would-be consumers, e.g., by queues or other non-price rationing devices (i.e., since, with zero price, price can't discharge the rationing function). If the terms of access afforded by the non-price rationing devices become too onerous from the consumers' point of view, they will seek services elsewhere, e.g., the private market. This appears basically to be the situation for the MOH system in St. Lucia.

The MOH system in St. Lucia exhibits various shortages. Thus, although the supply of general hospital beds might be regarded as adequate (neglecting locational factors), hospital services are adversely affected by shortages of supplies and medications. Indeed, the relatively high rate of drug sales in the private sector indicated that, overall, the MOH system is far from supplying the drugs consumers demand.

In many ways, however, perhaps the key supply constraint, particularly affecting the primary care services, is the low rate of availability of physicians services to the Health Centres. A physician is available in each Health Centre for only one "session" (of about three hours) each week, at any other time the patient will see the Public Health Nurse. This means, of course, that if a patient demands physicians services at any other time, he must seek them elsewhere. Moreover, during his three-hour session, the physi-

cian may frequently see 100 or more patients. Again, if the patient seeking physicians services finds this kind of queuing and hasty encounter too onerous, he will have to seek services elsewhere. And, as has been pointed out foregoing, many patients do just that.*/
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*/ The MOH, of course, recognizes the problem with physician services supply to the Health Centres and as one remedy for the position has embarked upon a program to deploy Nurse Practitioners to the Centres. I do not undertake here an evaluation of the probable success of this strategy.

I have not had time to undertake a systematic survey of the overall utilization rate of the Health Centres, i.e., what their output is. It is clear that, even if the physician saw 100 or so patients during each of his weekly sessions, the rate of output of physicians services per Centre per year would not be very high. However, the Centre is staffed by the nurse all during the week and she of course also delivers services, although of what kind and at what rate I am not clear. Each Centre appears to maintain a number of log-type records, i.e., the Doctors Book, the Casualty Book, the Dressing Book and the Injection Book. In the one Health Centre in which I examined these records they appeared to be in excellent order, always a gratifying indicator. If all of the Centres maintain such records, an investigator with sufficient time for the task could quite readily determine the kind and rate of output of the Health Centre network.
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Some Problems in the St. Lucia Health-Services Sector to which an Alternative Financing Scheme May Be Responsive

This section is not a canvass of all of the problems in the St. Lucia health-services sector which may well warrant attention in one way or another. Rather, I attempt to identify a few major (in my view, priority) problems to which an alternative financing scheme can be expected to be responsive.

A major problem for the MOH system here (shared by MOH systems around the world) is that pressure for delivery by the system of curative services overly compromises the capacity of the system to deliver preventive/promotive services. Here, as elsewhere, this problem is not just a matter of the total resources available to the MOH. Whatever that total, within realistic limits,

the pressures for curative services are inexorable and the curative-services domain tends to be a bottomless pit for a delivery system which is supposed to deliver services without user charge to everybody. Thus, simply providing more funding for the MOH system, although this may help to some extent, is not apt to provide a real remedy for the position. What is required is some kind of structural intervention (e.g., as by resort to an alternative-financing scheme) which will provide an acceptable way to take the curative load off the MOH's back. Thus, if the government's responsibility for arranging a fair and equitable system for financing the people's demand for curative health services can largely be discharged in some other (non-MOH) program context, the major role of the Ministry of Health can be re-defined such that it can move in the direction of becoming, in the main, a Ministry of Public Health.*/ If it obtains, this is a valuable result. Preventive/promo-

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*/ I say "major" role, and "in the main" because under any likely configuration of the health-services sector the MOH in St. Lucia will continue to finance and deliver some curative services.

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motive services tend to be, in the technical sense, "public" goods such that public financing is peculiarly appropriate for resource allocation to them. The MOH is the logical organization aegis to provide such financing. Under the kind of development suggested here, the MOH should be able to conserve more of its scarce fiscal capacity for the public financing of those important preventive/promotive services which, if not financed by the MOH, are unlikely otherwise to be publicly or privately financed.

It is important to take note that the MOH in St. Lucia is, precisely at this particular point in time, acutely aware of the problem of how to make more of its resources available for preventive/promotive activities. This

is because, pursuant to the national goal of "health for all by the year 2000," the MOH has embarked upon an effort to enhance the primary health care programs and activities, particularly at the local level and in the context of community participation. The approach entails, among other features, the fielding of new categories of health workers as members of health manpower teams, namely the Community Health Aids and the Environmental Health Aids who are expected to have largely preventive/promotive functions. Although the communities are expected to play an important role in this approach, it will also depend for its success upon the capacity of the MOH to participate in a significant way, including the provision of resources to in various ways support the program.

Another major problem in the health-services sector here is the way in which the demand for services is financed in the relatively large and flourishing private sector--namely, for the most part, by out-of-pocket payments by consumers. It is true, as I have noted, that some (unknown number of) employees enjoy the advantages of Group Health Plans issued by private insurance carriers. It also appears to be the case, however, that most health insurance here takes the form of individual policies which necessarily entail relatively disadvantageous terms for the policy holder. For most consumers, as matters stand, including the 40 percent or so of the labor force self-employed as farmers, private Group Health Plans are not, in the nature of their employment situation, available.

There is, of course, nothing inherently amiss in having a large private health services sector. Indeed, there would seem to be no prima facie reason to suppose that government bureaucracies enjoy a comparative advantage in the management and administration of health-services delivery systems such that governments should be regarded as having a responsibility to go

into the health-services delivery business and seek to displace private delivery systems. The way in which the demand for services delivered by the private sector is financed, however, is quite another matter. Here, it might be argued, government does have a responsibility to see to it that consumers have an opportunity to participate in fair and equitable social-financing schemes, rather than being left to the disadvantages of out-of-pocket payment or disadvantageous insurance schemes.

Another major problem in the health-services sector here is the high cost of health services to the purchasers of them--namely, individual consumers in the private market place and the MOH system. Survey research would be required to determine what consumers are spending for health services (unit prices and total expenditures). However, some general orders of magnitude can perhaps be inferred from another available source, namely premiums charged for health insurance policies. It is my understanding (based upon casual empiricism, not systematic study) that for a representative Group Health Plan, the premium for coverage of the employee beneficiary and his dependents is about \$33.00 per month. For individual policies, the premium would be about two-thirds higher. For many consumers here, premiums on this order would impose quite a burden, as would the underlying rates of expenditures for medical care which they to some extent reflect.*/ For example, as of June, 1981, monthly earnings in six of the lower-paid occupations

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*/ Although these plans are financed by, say, 50/50 employer/employee contributions, it is probably a fair assumption that the employee bears the incidence of the total premium, i.e., the insurance benefit increases the employer's labor costs such that the employees are able to extract less in the form of wages and/or other benefits than they otherwise could. This result, of course, depends upon some assumptions about price-making behavior which may or may not hold here.

It is uncertain the extent to which such premiums reflect underlying rates of expenditure in the population as a whole. The premiums must reflect

average rates of expenditure by the insured beneficiaries for insured services plus some loading for the cost of doing business and profit for the carrier. Owing to this loading, the premiums overstate average expenditure. However, these plans feature limits on the carrier's liability for the various classes of coverage, i.e., they are not intended to reimburse all of the beneficiaries expenditures, and to this extent, the premiums understate these expenditures. (I do not know what proportion of the average beneficiary's average-yearly medical expenses these plans cover, survey research would be required to get a handle on this.) To the extent that insured individuals tend to spend more on medical care than uninsured individuals, the premiums would overstate expenditures by the latter.

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(street cleaner, labourer/government, sales person, labourer/agriculture, machine operator/garment and general factory hand) averaged (unweighted) just \$267 per month (assuming full-time employment at the reported weekly or monthly wage).*/ Thus, for these employees, the Group Premium cited

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*/ Data from: Statistics of Wages, Average Weekly Earnings and Hours of Work Obtained in Principal Industries, Occupations and Services from January 1975-June 1981 (St. Lucia Ministry of Labour, mimeographed document, undated). I have taken the midpoint of the wage or salary range in each case.

As one would expect at this stage of St. Lucia's economic development, the wage structure exhibits large wage differentials. Thus, for six middle-level occupations (construction/government/various building trades, accounting machine operators, senior clerks/gov. and pressmen) the average monthly earnings are \$663/month.

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above represents nearly 13 percent of income, a heavy burden indeed at these low levels of income. One problem with private health-insurance plans as they are usually administered is that they provide no mechanism for redistributing the burden in favor of the lower paid beneficiaries, i.e., each employee beneficiary pays the full freight. Public insurance schemes, on the other hand, typically entail some subsidy for consumers in lower income brackets.

The MOH is a large-scale purchaser of medical goods and services, notably those used as inputs to its delivery system. Particularly in the general hospital sector, the cost of these inputs is considerable. Thus, according

to the Approved Estimates for 1980/81 (the 1979/80 Actuals were not available) Victoria Hospital incurred a cost of \$68 per patient day.*/ Of this, about

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*/ This assumes an 85 percent occupancy rate, for an average daily census of 170 and a total of 62,050 patient days. Personal emoluments came to \$2,652,881 and other expenses to \$1,538,652.

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\$43 went for wages and salaries (so-called personal emoluments) and about \$25 for other expenses. The relatively high rate of wage and salary expense reflects in part a major problem for the MOH, namely, the high cost of physicians services. The government salary scale for Medical Officers without private practice privileges is, according to 1981/82 Estimates, \$16,980-\$18,420 and with private practice \$12,396-\$16,176. These salaries, which appear to be well below the supply price for these services, do not appear to be the only problem.*/ Another problem is that the MOH has agreed to pay

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*/ Under one Group Health Plan, the schedule of benefits provides \$25 for a specialist consultation. Assuming that the specialist worked only five days a week, fifty weeks a year he would still at these fees have to see only three patients per working day to earn at a rate equal to the top of the government's salary scale for physicians.

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the physicians not only their salaries, but also on a fee-for-service basis for the services they deliver. Perhaps this arrangement has been necessary to meet the supply price for the services such that little can be done about it. In any event, however, the MOH has a strong preference that any alternative financing schemes which might be adopted contain features which would facilitate more effective cost containment in the health services sector, particularly as regards the cost of physicians services and drugs and medications.

Having in this section identified three major problems in the health-services sector here to which an alternative financing scheme should be responsive, we may now turn to the alternative scheme.

An Alternative Financing Scheme for Health Services in St. Lucia

In this section I sketch just the broad outlines of the proposed scheme. Discussion of some of its features will follow in the next section.

The central feature of this proposal is a National Health Insurance Program (NHIP) to be operated as a Division of the existing National Insurance Scheme (NIS).*/ NHIP is to be a modified social-security-type scheme. The

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*/ NIS now provides old age, survivors and other income-replacement benefits for employees in St. Lucia. It does not now enroll the self-employed nor does it provide health-insurance benefits. NIS is financed by employer/employee contributions, each set at five percent of wages and salaries up to a wage/salary maximum. I have not been successful in locating data on revenues and expenditures for NIS. However, it appears that as is usual (and intended) for such schemes in LDCs, NIS earns a substantial surplus which is loaned to the government for various purposes.

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beneficiaries would be employees and their dependents and most of those self-employed in the agriculture and other sectors and their dependents. Funding would come from employer/employee contributions set as a percent of wages and from collective contributions from the self-employed who would be enrolled on a group basis. NHIP would establish a schedule of benefits to be paid for services provided by the private sector. These payments might go to the beneficiaries or to the providers if they accept assignment (i.e., agree to take the scheduled benefit as full payment for services rendered).*/

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*/ Whether this feature or, more generally, any other particular feature of NHIP could be included in such a program as implemented would depend upon not only what might make sense in principle but also upon what would prove

administratively feasible, including the matter of coping with potential abuses of the system by beneficiaries and providers. This preliminary stage in the consideration of NHIP is not the place to attempt to engage these issues. If, in terms of its broad outlines, a NHIP-type scheme should appear attractive enough to the government of St. Lucia to warrant follow-up study, these operating issues would be engaged at that time.

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NHIP would also establish a schedule of benefits to be paid for certain services provided by the MOH system (what services and what benefit rates to be worked out).*/ NHIP payments for services provided by the MOH system would

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*/ This is, of course, an unusual feature in the relationship between a social-security-type scheme and an MOH system. It is not, however, unique. The national health-insurance scheme in the Philippines pays benefits for hospital services provided by the MOH system there.

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go directly to the MOH or to the providers and suppliers of services delivered through MOH facilities.

Foregoing are the basic features of NHIP which, in its broad outlines, is quite straightforward. Of course, the actual implementation of any such scheme is apt to prove much less straightforward. We may turn to some discussion.

SOME FEATURES, BENEFITS AND PROBLEMS OF NHIP

Including the Agriculture Work Force

The enrollment as beneficiaries of those self-employed in the agriculture sector and their dependents is an important and novel feature of NHIP as contrasted with conventional social-security-type schemes which operate solely in the modern, non-agriculture sectors of the economies of those countries with such schemes.*/ For various reasons (financing format, administra-

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*/ As previously noted, self-employed persons in addition to those in agriculture would also be included (if they could be organized in a way to facilitate collective enrollment and collective contributions). To keep the discussion within manageable bounds, I address the situation of those self-employed in agriculture as exemplary.

It is true that some social-security-type schemes offer individual enrollment to the self-employed. This approach may be feasible for some types of social insurance, e.g., pensions. It will not, however, work well for health insurance for various reasons including the fact that it results in what is known in the trade as "adverse risk selection."

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tive problems), since most of the agriculture work force in most countries is comprised of self-employed farmers, it generally has been regarded as not feasible to include them in such social-insurance schemes. At the same time, however, in many countries, the agriculture work force is the largest proportion of the total work force (it comprises about 43 percent in St. Lucia) and, moreover, incomes in the rural, agriculture economy are low compared with those in the urban economy. Hence, it is the members of the agriculture work force and their dependents who most need social-insurance programs. The key to including self-employed farmers in social-insurance programs is to find ways in which they can be enrolled and make contributions collectively. The possibility of this approach, in turn, depends upon the extent and nature of organization in markets for agriculture products.

Fortunately, in St. Lucia, organization in agriculture markets is pervasive, especially for the important export crops where most farmers are employed. Major organizations include the St. Lucia Banana Growers Association (this is the major crop in St. Lucia), the St. Lucia Coconut Growers Association, and the St. Lucia Agriculturist Association (cocoa, nutmeg). Farmers who produce vegetables and other crops mainly for domestic consumption are less well organized. At present, the St. Lucia Marketing Board, a government agency, provides marketing, input supply and agriculture extension func-

tions for these farmers. A move is now underway, under the aegis of the Ministry of Agriculture, to convert the Marketing Board into a farmer membership and farmer controlled organization on the pattern of the other Associations.

Representatives of the foregoing farmers' Associations with whom I have discussed this matter felt that their members might well find it attractive to be included in and make contributions to a NHIP-type health-insurance scheme through their Association, provided, of course, that the price was right (contribution rate) for the benefits received. Indeed, it appears that the farmers in St. Lucia have in recent years become increasingly concerned about this very issue, i.e., that of how they can be included in social-insurance schemes.

The design and administration of contribution schemes for health insurance funds based on the value of agriculture products entails some special problems, especially in countries such as St. Lucia where there is heavy dependence upon a few major export crops. Owing to the vagaries of weather (Hurricane Allen provides a recent, extreme example) and world markets, the value of agriculture production is apt to vary considerably from year to year, thereby threatening the stability of the insurance fund. The answer is to put such contributions on an "ever-normal fund" basis (analogous to the "ever-normal granary" strategy for stabilization of agriculture prices). Thus, in good years, contributions to the fund would be in excess of withdrawals from it, accumulating a surplus in such years. In bad years, withdrawals would exceed contributions, with the insurance-scheme drawing upon the surplus accumulated in good years. On average over many years, the contributions would match the withdrawals.

All of the beneficiaries in NHIP would be entitled to the same benefits. The contribution rates, however, might differ among the different groups of

beneficiaries. More particularly, in designing the scheme, the policy makers will want to consider the extent to which equity considerations might call for imposing a lesser financing burden upon groups of generally low income beneficiaries than upon groups of generally higher income beneficiaries, an approach which might in this way entail some cross-beneficiary subsidy for farmers.

Substituting Social Financing for Out-Of-Pocket Financing in the Private Sector

One of the problems identified foregoing which an alternative financing scheme should address was the extent to which, as matters stand, financing the demand for health services provided by the private sector relied upon out-of-pocket payments. NHIP would obviously address this problem, i.e., much of the demand now financed by out-of-pocket payments would be financed by NHIP benefits. The scheme might, however, include some acceptable level of consumer cost-sharing, i.e., out-of-pocket payments by beneficiaries in the form of deductibles or co-payments set at some fraction of the cost of services.

Relationships Between NHIP and the MOH System

Very careful attention will have to be given to these relationships. Although the outcome to be achieved in these relationships is quite clear, it is less clear precisely what arrangements will achieve this outcome.

Given the present configuration of the health-services sector in St. Lucia, it is likely that under NHIP, the private sector would continue to be the major provider of primary care. (Primary care in this sense is to be distinguished from the "primary health care" concept, largely preventive/promotive services which the MOH plans to develop at the community level.)

On the other hand, the MOH facilities would continue to be the major provider of hospitalization services, at least in the near term. It is proposed that NHIP benefits finance hospital services provided by MOH facilities to NHIP beneficiaries. For whatever services are to be financed by NHIP benefits, a decision will be required on the actual flow of these funds, e.g., whether they go to the MOH to defray expenses it incurs for the provision of these services or whether they go to the providers and suppliers of these goods and services.

The objective we seek to serve by structuring the relationship between NHIP and the MOH is to in this way help rationalize resource allocation to the health-services sector. Pursuant to this, we seek a situation in which these curative hospital services, although physically delivered in the context of an MOH facility, are regarded as provided by NHIP to beneficiaries of an insurance program, rather than being regarded as provided by the MOH to patients in general. Under this perception of the financing/delivery system, NHIP would be regarded as having responsibility for curative services such that the inevitable pressures for more funding for curative services would be directed to NHIP. The MOH would in this way be relieved of a major responsibility for curative services such that it could, as has been suggested previously in this discussion, move in the direction of becoming more nearly a Ministry of Public Health.*/

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*/ As was pointed out previously, the MOH would continue to be responsible for financing some curative services, e.g., for some of those who for institutional reasons could not be brought under the NHIP program.

Under these arrangements, the MOH would, of course, be relieved of a good part of the burden it historically has borne for the financing of curative services. Consequently, the policy makers would confront the question of the advisability of some partial offsetting reduction in the general tax revenues budgeted for the MOH. The MOH budget should be set at a level ade-

quate to fund those services (preventive/promotive, some curative) which are determined to be the responsibility of the MOH services, assuming that these services will be produced in a cost-effective way.

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There is another sense in which the foregoing arrangements may be said to help "rationalize" resource allocation to the health-services sector. One of the great problems in the economics of the health-services sector is how to bring the test of willingness-to-pay to bear upon the rate of resource allocation to curative services while, at the same time, serving the objectives of equity including fair access to services. As a social-financing scheme, NHIP serves these latter objectives, assuming that the total financing burden equitably is distributed among the various groups of beneficiaries. NHIP also entails a willingness-to-pay test because the volume of services which can in this way be financed depends upon the contribution rate. If the beneficiaries want more services to be financed in this way, they must increase their contribution rates.

Contributions to Cost-Containment Objectives

In a previous section, cost-containment was identified as one of three major problems for the health-services sector in St. Lucia to which an alternative-financing scheme should seek to be responsive.

One aspect of this matter has been alluded to in the last section. By bringing an acceptable willingness-to-pay test to bear upon the rate of resource allocation for curative services, NHIP in this way exerts appropriate pressure for cost-containment.*/

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*/ It should perhaps be remarked that even where health-services are financed out of general tax revenues, the rate of resource allocation to health services confronts a kind of willingness-to-pay test, i.e., the will-

ingness of the body politic to pay general taxes. However, general tax revenues finance government programs in general, there is no perceived direct connection between such tax revenue requirements and any one government program. e.g., health services. Tax payer resistance may signal the unwillingness of tax payers to pay in this way for "more government," but it does not signal their willingness-to-pay for more or less of any given service. Under contributory insurance schemes, on the other hand, there is a perceived direct connection between the taxes (contributions) and health services, i. e., the taxes are in effect earmarked for this purpose. This results in a very different kind of willingness-to-pay test than obtains under general tax revenue financing.

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Another aspect of this matter has also been alluded to, namely the possibility of including some acceptable level of consumer cost-sharing in the scheme. In the world of health insurance, consumer cost-sharing is a controversial topic and I do not undertake a general examination of it here. I may simply note that, in my view, appropriate levels of consumer cost sharing have a good bit to be said in their favor. Since consumer cost sharing does tend to cut down on the rate at which beneficiaries utilize services (without, at the same time, denying them fair access to services), it can be an important cost-containment feature. Serious consideration should be given to including some consumer cost-sharing in NHIP.

Finally, we may engage the special problem of the high cost of physicians services in St. Lucia, confronting both consumers in the private sector and the MOH. The basic problem is, of course, the supply-demand situation, physicians are in short supply in St. Lucia relative to the demand for their services.*/ Thus, when the MOH negotiates compensation rates for the physi-

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*/ The ratio of general practitioners to population appears to be about 1:6,000. In addition to relative scarcity, there is the problem of the absolutely small number of physicians, owing in part to the limited extent of the market. Thus, in each of the specialist categories, the number of physicians is from one to three.

cians it employs, it does so in a market in which there is an imbalance of bargaining power in favor of the physicians. The physicians know that if the MOH refuses to come up with their supply price, they can always make a handsome living in the private sector, a circumstance which is facilitated by the fact that in the private sector they will provide services to unorganized consumers, each with little bargaining power.*/
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*/ It has been my impression from various sources that physicians find practice in the private sector here quite profitable although, as pointed out in the discussion of the size of the private sector, I have not obtained definite information on physician incomes. The market for physicians services in St. Lucia is unusual in the extent to which it depends upon expatriate "contract officers." The implications of this arrangement require study in order fully to understand this market, e.g., implications for physician bargaining power.
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Under the NHIP proposal, certain elements in this picture would change. Much of what is now individual financing by out-of-pocket payments in the private sector would be financed by NHIP benefits. NHIP could undertake to represent the interests of its beneficiaries collectively by attempting, say, to negotiate fee schedules with the physicians, i.e., schedules with which they would have to comply as a condition of compensation by NHIP. That is, the consumers would be, in effect, organized collectively in their roles as NHIP beneficiaries such that they might be able to exploit their collective purchasing power in the market for physicians services and in this enhance their bargaining power to obtain services on better terms.

Under one format for this proposal, NHIP benefits would pay for in-patient physician services delivered in MOH owned hospital facilities. Under this arrangement, NHIP, rather than the MOH would negotiate compensation rates for these services. If, owing to their collective organization and

representation as beneficiaries by NHIP, consumers were able to obtain more favorable terms for physicians services in the private sector, this would make private practice a less favorable alternative for the physicians than heretofore. This would mean that NHIP might enjoy a better bargain power position vis-a-vis the physicians delivering in-patient hospital services than does the MOH under the present set up.

These relative bargaining power implications of NHIP are, of course, necessarily speculative. The basic supply-demand picture may be decisive in this domain such that little can be done to obtain physicians services on better terms. Nevertheless, there is always the possibility in imperfect markets of this kind that the returns to physicians include significant elements of what technically is known as "economic rent"--i.e., payments to physicians over and above what would be necessary to keep them in their present occupations here. If so, institutional changes in these markets which tend to redress the balance of bargaining power in favor of consumers may possibly benefit the consumers.

Conclusion

This report has identified three major problems in the St. Lucia health-services sector to which an alternative financing scheme should be responsive. A National Health Insurance Program (NHIP), to be operated as a Division of the existing National Insurance System (NIS) has been proposed as such a financing scheme. An effort has been made to show why NHIP would be responsive to the problems identified.

The question now is whether the Government of St. Lucia will regard this scheme, on the basis of the outline of it contained in this report, as sufficiently attractive to warrant serious follow-up study. If, in the view of

the Government of St. Lucia, follow-up is warranted, the next step would be the design and implementation of detailed feasibility studies.

Postscript

As it turned out, the Government of St. Lucia did express interest in further exploration of the suggestions made in this report, with an eye to possible implementation of a NHIP, I attach in what follows and as a part of this report an edited version of a memorandum I prepared, addressed to St. Lucia MOH officials (and to USAID/Barbados), to help inform these next steps.

July 14, 1982

Memorandum to: Mr. Lubin, Permanent Secretary, MOH, St. Lucia
Dr. D'Souza, Chief Medical Officer, MOH, St. Lucia
Mr. Randlov, USAID/Barbados

From: Professor Carl M. Stevens

Subject: Implementing a National Health Insurance Program (NHIP) for St.
Lucia

Introduction

My May 5, 1982 memorandum--"Alternative-Financing Possibilities for Health Services in St. Lucia"--suggested that the institution of a National Health Insurance Program (NHIP) might make an important contribution to rationalizing health-sector financing in St. Lucia. Interest has now been expressed in further exploration of that suggestion with an eye to possible implementation of a NHIP. This memorandum is responsive to that interest. The kind of NHIP contemplated herein is that sketched in my May 5 memorandum--namely, a contributory insurance scheme with contributions based upon wages or other transactions (e.g., in the case where self-employed farmers are to be beneficiaries of the program). Even if there is agreement "in principle," so to speak, that the institution of a NHIP would be appropriate, the policy makers should be wary of proceeding too rapidly with attempts to implement the scheme. A good bit of information is required for the design of an operational NHIP. Much of this information is not at hand, it will have to be assembled. Also, the design of an operational NHIP entails addressing a number of policy issues which should have a thorough airing. Discussions on

the policy front can go forward while the necessary information is being assembled.

This memorandum draws attention to some of the information that will be required, suggests why that information is required, and suggests some approaches to assembling that information. This memorandum also notes some of the policy issues confronted pursuant to implementation of such a scheme.

RECOMMENDATIONS for courses of action pursuant to the design and implementation of a NHIP are interspersed in the text where appropriate. Where these RECOMMENDATIONS call for actions such that technical assistance would be helpful and such that funds may be required to employ investigators (e.g., survey research), I recommend that the MOH explore the possibility of obtaining such assistance from USAID/Barbados.

A Note on Phasing in the NHIP

It has been suggested that the implementation of the NHIP might well be phased in, with some components of the scheme becoming operational in the near term and other components, necessary to fully develop the scheme, becoming operational at later dates. It may turn out that such an approach would be the best. However, it should be remarked that caution is required in following this course. One problem is that, as experience elsewhere has shown, once certain basic parameters of NHIP-type schemes are built in (e.g., contribution rates, level of beneficiary co-payments if any) it is very difficult subsequently to modify them (even though, in light of accumulated experience, such modifications would be in order). Consequently, before any component of a NHIP is initially phased in, the design work on the fully developed scheme should have been done such that the policy makers will have a firm idea of what the longer-run requirements will be.*/

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*/ This refers to components which are integral components of the NHIP. The NHIP itself might be regarded as one among several programs to be undertaken together such that collectively they would contribute to an overall effort to rationalize health-sector financing. Any such accompanying program, not an integral part of NHIP itself, might be initially phased in without running the danger alluded to in the text. Current thinking appears to be that an early initiative to contain costs of drugs would be appropriate.

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Utilization Rates under a NHIP

If the NHIP is to be self-financing, on balance over the years, total revenues from contributions to the insurance fund must equal the total paid out in benefits plus some allowance for administrative costs. What is paid out in benefits depends upon the utilization rates of the insured services by the beneficiaries and the costs of these services. Prior to the initiation of the NHIP, there is, of course, no experience under the scheme itself upon which to base estimates of utilization rates.*/ However, it may be

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*/ Once the scheme is operational, such experience begins to accumulate. The scheme should be provided with an information system which will permit systematic monitoring of the utilization rates exhibited by the various classes of beneficiaries. This information helps to inform adjustments in the scheme over time.

On the matter of adjustments, it will be appreciated that there is always some uncertainty with respect to future developments and the implications of these for the operation of the scheme. For example, such factors as changes in the state of the medical arts, changes in utilization patterns and the like may have the result that funding rates which at one time appeared adequate no longer appear adequate. And it will also be appreciated that the indicated adjustments to accommodate such developments may be difficult to achieve. In evaluating the policy implications of such problems, however, it is important to bear in mind that these problems are by no means peculiar to NHIP-type schemes. Thus, conventional MOH systems confront the same problems. Indeed, in many countries at the present time, rates of funding for MOH systems which at one time were regarded as adequate no longer are regarded as adequate. This situation has inspired much interest in finding alternative sources of financing for the basic health services delivered by such systems. And with MOH systems, as with other programs, the indicated adjustments are difficult to achieve.

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possible to draw upon other kinds of experience to inform the estimates. In considering the possibilities on this score, it will facilitate the exposition to consider the information requirements for a number of exemplary NHIP benefit patterns.*/
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*/ Although hypothetical for purposes of discussion, the example benefits considered in the text have been discussed as possibilities here. What the actual benefit package adopted should be is a matter which will require further discussion based on the findings of the data collection activities recommended in the text.
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One benefit pattern might include reimbursing the MOH for inpatient hospital services delivered by MOH facilities to the beneficiaries on more or less the prevailing terms of no out-of-pocket user charge. On this pattern, NHIP would feature only nominal deductibles and co-payments, if any.*/
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*/ This example does not imply a recommendation that NHIP should feature no more than nominal consumer cost-sharing by means of out-of-pocket deductibles and copayments. Indeed, there is a good bit to be said in favor of significant cost-sharing of this kind.

The significance of consumer cost-sharing is not always fully appreciated. The fact that an insurance-scheme financing package includes, say, out-of-pocket copayments, does not mean that, therefore, the burden on the beneficiary is necessarily greater. This is so because, owing to the revenue from the copayments, the contribution rate can be lower for any given size of program. Indeed, since the copayments will tend to reduce utilization rates, the total revenue required to finance the scheme (contribution plus copayments) will be less than for a scheme financed solely by contributions, i.e., the burden on the beneficiary may be less under the copayments scheme.
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For such beneficiaries, estimates of utilization rates might be obtained by a study of the operating experience of the MOH inpatient facilities. One such study would be facility based (mainly, Victoria Hospital), utilizing hospital records to determine the costs of care delivered to various classes of patients.*/
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*/ RECOMMENDATION I: That a facility-based study be initiated of the utilization of MOH inpatient facilities by various classes of patients (classified by, say, age, residence, income, employment status, sex). This utilization study would also classify patients by diagnostic category and would seek to determine the cost to the MOH of each class of patient (and, hence, class of prospective beneficiaries, were there to be a NHIP).

Also, that a facility based study be initiated of the utilization of MOH outpatient facilities (along the lines sketched for the inpatient utilization study).

In addition to helping inform the design of a NHIP, the information called for in this recommendation will be of importance for more general health-planning purposes.

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Such facility-based utilization studies will not directly yield population utilization rates (owing to the circumstance that there are other sources of care available to and utilized by the population served by these facilities). Nevertheless, this information is important. On one view of the matter, a major rationale for instituting a NHIP is that it will contribute to rationalizing health-sector financing in St. Lucia by relieving the MOH system of the financing demands of a good bit of curative care such that the MOH can direct its scarce general-tax revenue resources more largely to preventive/promotive activities. Consequently, under a benefit pattern in which a NHIP reimburses the MOH for services provided by its facilities to certain classes of beneficiaries, it is important to determine how much of the MOH's resources might in this way be freed for public-health activities.

Another kind of study to obtain information on the operating experience of the MOH would be population-based survey research. Such research should in any event be undertaken to obtain a wide range of information of use for the design of a NHIP and for other health-planning purposes.*/

*/ RECOMMENDATION II: That population-based survey research be undertaken to determine from where and at what rates individuals obtain health care for what kinds of illness and what expenditures are made by individuals for such care. The survey should attempt to elicit information on the reasons for use of non use of the various sources of care. The respondents should be classified by such characteristics as age, location, income, occupation, employment status, education attainment and type of health insurance (if any). In the design of the sample, particular attention should be directed to obtaining reliable information on the experience of individuals covered under private health insurance.

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In addition to reimbursing the MOH for services provided by that system, NHIP might insure beneficiaries for services they obtain from the private sector. Some of the information provided by population-based survey research (See RECOMMENDATION II) on the market experience of individuals paying out-of-pocket for services obtained from the private sector--notably, information on unit prices paid, would be directly helpful for the design of this kind of benefit. Information on the utilization rates exhibited by individuals paying out-of-pocket for services obtained from the private sector is less directly relevant since insured populations are apt to utilize services at higher rates than otherwise similar uninsured populations. (This utilization information might be regarded as establishing a kind of lower bound on utilization rates to be anticipated under NHIP for such beneficiaries.*/

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*/ More generally speaking, such utilization information is useful in giving a picture of the size and character of the private sector and its importance relative to the public sector, a picture useful to inform the more general health-planning decisions that would accompany the implementations of a NHIP.

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On the other hand, information on the utilization rates exhibited by

individuals covered by private health-insurance carriers (particularly those insured under group policies) is apt to be directly relevant for the design of NHIP benefit packages for individuals obtaining services in the private sector. Indeed, this information is of such potential importance that, in addition to seeking it via population-based survey research (See RECOMMENDATION II), an effort should be made to obtain information from the carriers themselves and from the employers who are parties to such policies.*/
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*/ RECOMMENDATION III: That a survey be initiated of the private health-insurance industry based on information obtained from the carriers and from the employers who are party to group plans. The survey should determine the extent of group coverage (and also of individual coverage). It should determine the kinds of policies being written (premium costs, benefits, mode of reimbursement of providers), and the number of beneficiaries covered under each. An attempt should also be made to determine utilization rates under the various kinds of policies. The experience of employers who directly provide health plans for their employees (who "self insure" in this sense) should also be canvassed.
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The Benefit Package under a NHIP

A wide range of choices is available for the design of the benefit package, e.g., with respect to the kind of consumer cost-sharing (deductibles, copayments) if any, limits on coverage, service benefits vs. cash indemnities, and other features. These choices will turn in part upon information to be assembled by the data collection activities recommended in the context of this memorandum. In this section, I will briefly discuss some general principles which may also inform these choices.

From the beneficiary's point of view, a major advantage of financing his demand for medical care through insurance (as contrasted with out-of-pocket payments) is that the beneficiary may in this way insure himself against the risk of having to make extraordinary expenditures for care at

some point in time and against the risk of being unable to obtain needed care because of inability to finance such expenditures. Indeed, in the view of some, insurance against such risk is the only "rational" reason for health insurance. In this view, so-called "major-medical" insurance makes the most sense, i.e., insurance schemes under which the beneficiary is liable for substantial out-of-pocket payments (consumer cost-sharing by deductibles, co-payments) over the usual range of small expenditures but is protected under the scheme against having to make large expenditures (such a scheme may incorporate a so-called "maximum risk" level of expenditure above which the beneficiary makes no more cost-sharing payments out-of-pocket). Since only a relatively small proportion of total medical care expenditures is made up of large expenditures, contributions to an insurance fund to cover only major-medical benefits can be significantly less than those contributions required to support plans which afford so-called "first-dollar" coverage (i.e., cover all medical expenses incurred by the beneficiaries). Thus, if a NHIP were to adopt the major-medical approach, it could feature relatively modest contributions to the insurance fund.

On the other hand, there are those who contend that a major advantage from the beneficiary's point of view of financing his demand for medical care through insurance inheres in the prepayment for care entailed by such schemes. On this view, health insurance is not just insurance against risk, it is also and importantly a way to pay for medical care which relieves the consumer of the disutility of having to regard the consumption of health care as an "economic" choice at the consumption choice point. If a NHIP were to adopt the first-dollar coverage approach, it would feature relatively large contributions to the insurance fund,

NHIP might, of course, adopt any of a range of alternatives between the pure "first-dollar" coverage approach on the one hand and a high "maximum risk" major-medical approach on the other--these alternatives depending upon the way in which consumer cost-sharing by deductibles and copayments are designed into the scheme. Presumably, the preferences of prospective beneficiaries, if these can be elicited, would be an important determinant of the choice among such alternatives.

Relationships with Providers Including the MOH

The historical costs of services (adjusted for anticipated inflation) provide a starting point for estimating prospective costs to be anticipated under a NHIP. However, we should not lose sight of the possibility that the historical track record of costs might in various ways favorably be modified under a NHIP. More particularly, upon the institution of a NHIP, it may not be necessary simply passively to accept the pre-existing market arrangements and pre-existing health-care production functions. For example, the institution of a NHIP might be accompanied by some kinds of regulation, e.g., on the retail prices of certain important drugs in the official formulary. Also for example, for beneficiaries obtaining services from private providers, it might be possible to arrange for provider compensation on a capitation (so much per beneficiary-month) basis rather than on a conventional fee-for-service basis, or to in other ways obtain services on more favorable terms. (This prospect is enhanced by the consideration that a fully developed NHIP would represent substantial aggregate purchasing power in the medical market place and consequently might enjoy substantial bargaining power.)

It is perhaps unnecessary to remark that, at this preliminary stage, the prospects for successful implementation of initiatives such as those

suggested foregoing must be regarded as speculative (in each case, problems would be encountered). The general point is, however, that the institution of a NHIP might be regarded as an occasion upon which a more general and broad-scale effort was made to rationalize health-sector financing, including the important matter of attempting to contain the costs of medical care. To the extent that such efforts succeeded, the prospects for a successful experience under a NHIP would be enhanced.

Relationships between a NHIP and the MOH system involve a number of problems which will need discussion. Some of these turn on the implications of the "free care" obligations of the MOH and what the status of these obligations is apt to be under a NHIP. As I understand the position, as matters now stand, the MOH is obligated to deliver free care to the entire population, i.e., to any and all patients who present. It is also my understanding that, prior to June 1980 this was not the case, that prior to June 1980, some categories of patients were entitled to free care (call these the entitlement patients) and other categories of patients were not entitled to free care (call these the non-entitlement patients). Generally speaking (i.e., with certain exceptions), employed persons between the ages of 15 and 60 years and earning more than \$1,500 per year made up the non-entitlement group (estimated at about 15 percent of the population), the rest were entitlement patients. It may be helpful to consider some of the implications of the pre-June 1980 scheme.

The proviso that patients are entitled to free care (the entitlement patients) means that these patients are not to be billed for services provided. However, the MOH obviously has to "bill" somebody for the care provided these patients, i.e., as matters stand, the treasury (the general tax payers). In principle, under the prior scheme, the non-entitlement patients

could be billed directly for care provided to them. If a NHIP were constituted and such a proviso were agreed to, the MOH could "bill" NHIP for services provided to patients. Under this arrangement, a question arises concerning the status of the entitlement patients and non-entitlement patients respectively.

If the MOH were to bill NHIP for services provided to non-entitlement patients, this would clearly seem not to represent a break with the pre-June 1980 policy. The non-entitlement patients would also be those, by and large, who were making contributions based on wages (or other transactions) to the NHIP insurance fund. From an equity point of view, the question might arise whether, as compared with the entitlement patients, the non-entitlement patients were "paying twice" for their health services. In a sense, perhaps, this might be true, but it would also seem to be in line with the pre-June 1980 policy which says, in effect, that employed persons 15-60 years of age and earning more than \$1,500 per year are not entitled to free care, i.e., alternatively they could have been billed directly out-of-pocket for their services. The principle would appear to have been that, pursuant to distributional objectives, it was appropriate that the non-entitlement patients' general tax payments on health-services account should go to defray the costs of care for the entitlement patients, leaving these non-entitlement patients to pay for their own care by other means.

More difficult questions arise under a pattern in which the MOH would bill NHIP for services provided to entitlement patients, i.e., in effect, regarding them as beneficiaries of NHIP whether or not they made contributions to the insurance fund.* / Would this represent a break with the pre-

* / It would seem reasonable to include those previously designated as

entitlement patients who are dependents (appropriately defined) of contributing NHIP beneficiaries as beneficiaries under NHIP.

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June 1980 policy? It would not literally represent a break in the sense that these patients would not themselves be billed directly (the definition of "free" care)--rather, in this case, the MOH would just bill NHIP rather than the treasury. However, potential equity problems are more manifest in this case. Under this arrangement, those individuals financing NHIP by their contributions might reasonably regard themselves as "paying twice" to defray the medical expenses of the entitlement patients, i.e., once through their general tax payments and once through their contribution to the NHIP insurance fund. Whether this kind of equity argument might constitute a real bar to a pattern under which NHIP reimbursed the MOH for services delivered to entitlement patients I do not know. However, it would seem important, early on in thinking about implementing a NHIP and in thinking about the relationships of NHIP to the MOH system, to try to work out the implications of the pre-June 1980 distinction between entitlement and non-entitlement patients and to think about what the provision on this score should be under a system in which both a NHIP and the MOH are operating.

Generating the Insurance Fund for NHIP

As we have been discussing it, and as I have been assuming in this memorandum, NHIP is to be a modified social-security-type scheme. The beneficiaries would be employees and their dependents and most of those self-employed in the agriculture sector and other sectors and their dependents (when the scheme is fully phased in). The inclusion of the self-employed, particularly in the agriculture sector which represents a large percentage of the

total work force, would be a novel and valuable feature of NHIP as compared with traditional social-security schemes.

Under NHIP, funding would come from employer/employee contributions set as a percent of wages and from collective contributions from the self-employed who would be enrolled on a group basis. For the self-employed farmers the contributions would be based upon the value (sale/purchase) of agriculture products. In thinking about the design of a NHIP, information will be required on what rate of funding can be expected from various contribution rates based on wages and on the value of agriculture products. Owing to prior experience under the existing NIS, information on the revenue yield to contributions based on wages (the way in which NIS is funded) should be readily obtainable. However, some study will be necessary to determine what revenue yield may be expected from contributions based on the value of agriculture products. Given the intention to enroll as beneficiaries of NHIP self-employed farmers on a group basis to make their contributions collectively, the relevant agriculture products are those produced by farmers who are members of Associations who can play a role in administering such a scheme, i.e., at present, those represented by the St. Lucia Banana Growers Association, the St. Lucia Coconut Growers Association and the St. Lucia Agriculturalists Association. (If and when the St. Lucia Marketing Board is converted into a membership organization on the same kind of pattern as the other Associations, it too would be included here.)*/

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*/ RECOMMENDATION IV: That a study be initiated to determine what revenue yield for a NHIP insurance fund might be expected from contributions at various rates based on the value of the major agriculture products, e.g., bananas, coconuts, cocoa and nutmeg, the producers of which are organized into effective Associations. This study should be retrospective over a number of past years to obtain some notion about the stability of funding

to be expected from this source and to establish the average yield which might be expected on the basis of that past experience.

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Conclusion

As pointed out in the Introduction, this memorandum has been responsive to the interest which has been expressed in further exploration of the possibility of instituting a NHIP in St. Lucia. As such, it has been the main intention of this memorandum to recommend some courses of action, mainly to assemble information, which will contribute to possible implementation of such a program.

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