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**FINAL REPORT**

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**ASSESSMENT OF HEALTH FINANCING NEEDS  
IN THE EASTERN CARIBBEAN WITH PARTICULAR REFERENCE TO  
DOMINICA, GRENADA, ST. KITTS, and ST. LUCIA**

**Contract No. 538-0000-C-00-1165-00**

**Final Report**

**by**

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**Submitted to:**

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## **EXECUTIVE SUMMARY**

### **PURPOSE**

The purpose of the proposed project was to assist the countries of the Eastern Caribbean to improve the financial situation of their health sectors. The issues addressed in this assessment, with specific application to the health care financing sector, included:

- Whether USAID assistance is needed and appropriate;
- The purpose of such assistance;
- Realistic outputs for any proposed assistance program given current circumstances; and,
- The need for training, research, testing of revised management systems, policy dialogue, equipment, and materials in the Eastern Caribbean countries, if the projected outputs are to be realized.

### **FINDINGS**

It will be useful to improve the financial resources of the health sector in the Eastern Caribbean, particularly hospitals, by:

- Determining the interest and ability of the Eastern Caribbean countries to cooperate regionally in the development of health care financing policy and health care financing systems;
- Providing education about health economics and health policy options to policy makers, administrators and to the public;
- Devising politically acceptable systems to collect fees from persons capable of paying;
- Providing training in financial analysis for the public health sector;
- Planning financially rational ways to maintain the range of health services presently provided;
- Providing training in hospital financial management to assure full protection and optimal use of hospital funds;
- Developing and implementing management information systems;

- Implementing hospital management systems, improved management practices and procedures, and establishing effective management systems and controls; and,
- Developing stable logistics funding and materials management systems to assure constant and adequate stocks of supplies of medicines.

## **OVERALL RECOMMENDATIONS**

- Empower Ministry of Health and hospital staff to execute their jobs.
- Facilitate strategies to enable policy makers to take rational and constructive action.
- Inform the public about health care financing options available to the government and about their personal choices and responsibility.
- Create equitable circumstances to assure that all persons have access to a basic standard of care, either free or according to their ability to pay.
- Facilitate access to a higher standard of care for those who can afford it in a way that fosters cross-subsidization of care for others who need it.
- Promote regional options that minimize regional costs and balance each country's technology investment, return on investment, balance of payments, and inconvenience to the sick.

## **SPECIFIC RECOMMENDATIONS**

1. Provide technical assistance by:
  - a. staffing the project regionally;
  - b. focusing on training; and,
  - c. requiring consultants and counterparts to achieve the transfer of systems-level capability for all technical assistance provided.
2. Provide a forum for policy analysis and discussion with politicians to explore health care financing options and the commitment to universal care.

3. Phase the implementation of the overall regional project by involving the strongest leadership of the different countries in significant parts of the project.
4. Initially train self-selected people from several countries simultaneously through a series of joint meetings intended to continue the development of regional consciousness about health care financing. Do this in the context of institutional strengthening and intergovernmental cooperation in development for the whole region.
5. Provide opportunities for all countries of the Eastern Caribbean (EC) to receive the same development assistance jointly and simultaneously.
6. Assist in the development of social marketing programs to enable governments to inform their citizens about the
  - a. costs of health care,
  - b. present sources of payment,
  - c. options and long-term costs of improvements,
  - d. role of citizens in controlling utilization of health resources, and
  - e. options for obtaining care.
7. Develop a regional data base for health care financing and epidemiological data. Cooperate with other technical assistance or donor agencies to obtain data and/or supplementary data bases. Provide the data to all EC governments to be used for health policy analysis. This will promote the development of regional analysis capability and regional policy formulation.
8. Provide training in policy analysis to help make decisions about the role of social insurance in health care financing.
9. Provide analysis and training to determine the role of commercial insurance companies in a voluntary, or in a government-mandated, insurance program.
10. Provide training in understanding the impact of commercial insurance on people's behavior, and vice versa, to improve insurance products and their contribution to health care funding.
11. Provide training in policy analysis to support decisions about health care financing privileges for the indigent and the medically indigent and the self-paid.
12. Provide training in health planning/analysis for:
  - a. analysis of the impact of capital investments on recurrent costs,
  - b. comparative analysis of the uses of capital,

- c. comparative cost analysis of obtaining services out of country with capital investment,
  - d. comparative analysis of depreciated long-term costs and the benefits of cost avoidance by not funding depreciation,
  - e. cost analysis to determine about how much of the cost should be passed directly to patients,
  - f. cost aspects of individual and collective health risk appraisal, and
  - g. other cost-benefit and financial analysis.
13. Provide administrative training in
- a. management systems,
  - b. financial systems,
  - c. management information systems, and
  - d. staffing systems
- to enable administrators to control the functioning of their agencies and hospitals.
14. Provide training in the realistic use of budgeting to encourage the funding processes to be more predictable and supportive of good management.
15. Develop an informed understanding of institutional risk and board members' personal risk in reorganizing hospitals around legally-constituted governing boards with fiduciary responsibilities.
16. Provide assistance for policy making to determine how persons entitled to subsidized care will be recognized as eligible for care.
17. Support privatization by training in decision analysis and impact assessment.
18. Provide training and models for health care demand studies.

## **I. INTRODUCTION**

This report was developed under Contract #538-0000-C-00-1165-00 with the Agency of International Development, in response to a request by the Health Office of the USAID/RDO/C in Barbados. The purpose of the consultation was to obtain information on the needs of selected countries in the Eastern Caribbean for technical assistance in health system organization, financing and sustainability. The information presented in this report is intended to support the development of a Health Project Identification Document (PID) and subsequently the design of a health care financing project targeted at the eight Eastern Caribbean countries.

It is expected that the new project will provide technical and other support in health financing and sustainability to the health systems in the region. Technical assistance will be provided through the health services sustainability project to be designed during FY92 by USAID/RDO/C.

The consultants' work began on September 30, 1991, and ended on October 31 with a debriefing at the USAID/RDO/C offices in Barbados.

### **A. METHODOLOGY**

The findings in this document are the result of interviews with approximately fifty persons. (The names of all persons interviewed are contained in Appendix B.) Interviews were held in Barbados, Dominica, Grenada, St. Lucia, and St. Kitts. (A full itinerary is included in Appendix C.) Summary findings from the country visits are included in Appendix D. These countries were selected by USAID for this fieldwork because they offered the best preliminary information about health services in the region. Data collected in these visits have been used to specify the categories and nature of assistance to be offered in the new project and as the basis for recommending assistance strategies. Findings are anecdotal and impressionistic. The observations contained in this report are the contractor's and do not necessarily reflect government policy or definitive plans.

In addition to interviews and field observations, the work of previous consultants was reviewed in order to learn the history of the development of health services in the Eastern Caribbean region, as context for formulating recommendations. Also, prior to undertaking the field visits, the contractor became familiar with the data base being accumulated by the RDO/C as a basis for developing comparative and trend data about the countries visited. The review of these and other background documents helped to obtain information on the significant trends and background data in the region. This review found the following areas significant:

- Reports of average and marginal hospital cost studies;

- Sources of health sector income;
- Allocation of health care expenditures by category;
- Health services utilization and coverage;
- Cost recovery;
- User fees and willingness to pay;
- Cost containment and methods improvement; and,
- Management information systems.

## **B. SCOPE OF WORK**

As stated in the Scope of Work, this report focuses on recommendations to USAID on the following issues:

- Whether USAID assistance is needed and appropriate;
- The purpose of such assistance;
- Realistic outputs for any proposed assistance program given current circumstances;
- The needs for training, research, testing of revised management systems, policy dialogue, equipment and materials in the Eastern Caribbean countries, if the projected outputs are to be realized; and,
- Which Caribbean technical or administrative organizations are appropriate and capable of collaborating in managing and implementing the suggested program of activities on a region-wide scale.

The full Scope of Work is in Appendix A.

This report recommends a general framework and identifies areas within the health sector which could potentially benefit from developmental assistance. The recommendations are based on an evolutionary concept of health systems with three guiding principles:

- Basic health services should be available before investment is made in advanced health services.
- Financial stability of basic existing health care services should be assured before more costly and less beneficial services that do not address basic health services needs are offered.
- Health care programs with high capital and recurrent costs should not be undertaken
  - without responsible assurance that their support would not financially jeopardize essential services; and,
  - without assurance that providing the service locally is the most cost effective method to obtain the service.

Once the health sector financing project is developed, certain criteria should be used to select the countries that will receive developmental assistance, including that:

- The country has the will and the staff interest to implement the programs that result;
- The work is necessary to promote further development of the health services of the country; and,
- The country will cooperate to develop staff skills and improve their health care financing and infrastructure.

The countries visited are having difficulty financing their health care sectors at the level of services they have provided to their populations in the past. This is due to increases in costs and to gradually expanding expectations in the health services sought. Since it is difficult to separate the areas of the health sector that might be improved from their financial aspects, we have listed below some areas of the health system that are in need of attention but which are beyond the scope of this assessment. Nevertheless, these areas will benefit from the improved planning or management of information services and from additional resources from the improved capitalization, budgeting, and revenue generation that should result from health sector financing developmental assistance, including the following:

- Access to emergency and acute medical services;
- The conditions of hospital physical plants and equipment, except as discussed under capital funding;

- Social complications of out-of-country referrals, such as removing sick persons from their families when they are ill (only the cost of referrals is addressed here);
- Which equipment to modernize and what new diagnostic and therapeutic technologies to introduce (only the issue of capital funding of equipment is addressed here);
- The strengthening of clinical skills of practitioners (There is a relationship between clinical skills and cost that includes consideration of the quality of clinical judgment and the availability of technology. The arguments that clinical judgments are better with and without high technology have been made. Both arguments are true in some circumstances. The risk is that costly high technology may not produce the most health care benefits per dollar and that the technology puts additional strain on barely constant recurring funding capability. This issue is addressed under capital funding and under regional cooperation.);
- Reduction of the incidence of complications and of hospitalization of patients with common chronic diseases, such as diabetes and hypertension;
- Strengthening application of epidemiological principles and methods for chronic disease control and prevention;
- Implementing preventive maintenance capability and training personnel in the necessary techniques; and,
- Continuity and quality of patient care.

### **C. THE CURRENT ROLE OF DONOR AND TECHNICAL SUPPORT AGENCIES**

A meeting was held with the RDO/C Project Design Committee. Discussion of the Scope of Work clarified the following issues:

- Sustainability is not to be a focus of the health care financing project at the early stages.
- Most indicators of health status in the region are satisfactory. The main goal of the project is to enable countries to maintain these indicators.

- The focus of improvement of health services is for persons in the bottom quartile. The improvement in financing the overall sector will also provide improvements in health status.
- Areas of assistance may be macro-policy initiatives, such as the relationships of fee structures to accessibility to health care.
- The increasing demands for medical technology and its high cost suggest that some progress toward regionalization of such services should be assessed.
- Interest in national health insurance schemes should be assessed.

The TvT consultants met with the former United Nations' consultant to CARICAD (the Caribbean Center for Development Administration), who has had extensive experience with health and management projects funded by donors and international agencies. He reported:

- Experience with previous policy-oriented health initiatives;
- The recent climate in the Caribbean in regard to administrative reform of health systems and the opinions of citizens about the health services they were receiving;
- The need for education of the people about health promotion, disease prevention and the costs of providing health care services;
- The difficulty of governments to increase funding in the health sector at the rate required; and,
- The high cost of technology and the need to make responsible decisions based on epidemiology, cost-benefit analysis, and geography.

A meeting was held with the Delegation of the Commission of the European Communities. Issues discussed included the level of funding and the type of projects presently underway or planned for the states which the team visited, as follows:

- St. Lucia will receive funding in the amount of 2.5 million EC for improvements to the Victoria Hospital.
- St. Kitts will receive support for computerization and repairs of hurricane damage to the hospital and health centers.

A meeting was held with representatives of the Pan American Health Organization (PAHO). Discussion focused on the program interests of PAHO and the nature of interaction between technical support agencies and donor agencies. New technical assistance activities planned for PAHO include:

- Reviewing the relationships between donor agencies and technical cooperation agencies to avoid duplication and promote continuity in the effects of support given;
- Promoting strategic management planning and cost effectiveness;
- Conducting a study of cost recovery for the hospital in St. Kitts; and,
- Providing support for the development of planning health care services and management information systems to support it.

## **II. MANAGEMENT AND STRUCTURAL IMPROVEMENT NEEDS**

### **A. HOSPITALS**

As context for the discussion of management and health sector management improvement needs in the Eastern Caribbean, the following observations about the development of their health service systems are provided.

Typically, demand for health care resources should stabilize with program maturity, after services are staffed and equipped. However, in most of the countries visited, the demand for resources has not stabilized because of inadequate long-term funding. In some cases, program growth has stopped, primarily because of a lack of funding rather than the development of competing programs or lack of unmet need.

Secondly, stabilization occurs when management anticipates and provides for:

- increases for demands for units of service;
- the addition of new services and technology; and,
- capital and operating funding for these events.

In most of the countries visited, however, funding is not sufficient to provide for this type of administrative responsiveness.

Realistic financial commitments that anticipate contingencies and are protected from forced reallocations are necessary. But, in the Eastern Caribbean, reallocations are part of common administrative practice due to the need to accommodate contingencies as they occur. Spending is generally closely controlled, so that budgets are not used as realistic spending plans.

Hospital service exists independently or as support to other referral programs. The utilization of hospital beds is controlled by the processes of admissions, transfers and discharges. Payment for hospital services, if sufficient to support the enterprise, should reflect the value of the service received. In some countries, governments have preferred to provide hospital services without payment. Over time, this has damaged the hospitals' capacity to care for the sick. Governments are now grappling with the following issues to revitalize and protect their hospitals and their citizens.

### **1. Hospital Governance**

Several countries are aware of the option of upgrading hospital governance by appointing a board and granting it authority and autonomy to administer the hospital. Such hospital Boards of Directors would have responsibility for disbursements and stewardship of hospital funds, and should control revenue and expenditures. Independent hospital boards and administrative upgrading are seen as a way to make the health system self-sustaining.

**Developmental Assistance:** There seems to be a consensus that organizing the hospital around a legally constituted governing board with fiduciary responsibilities for the hospital is desirable. However, there are also risks that the board can lose its central government resources and be left without resources. Without a legislative mandate that specifies the basis on which funding is to be provided, a change of governance may be unwise. It would be useful to support a policy analysis to:

- Review the results of changes of governance structure in other countries,
- Identify the financial circumstances that make the option advisable, and
- Set out criteria to advise governments of the circumstance under which it would be advisable.

### **2. Purchasing and Inventory Practices**

All countries are experiencing increases in inflation and in the prices of supplies purchased abroad. Typically, the budget for supplies is provided by the government based on funding for previous supplies and estimates of future requirements. Budget committees in each ministry make estimates based on previous

expenditures. The budgetary process does not usually involve the department head in the estimates. Spending is routinely delayed for all but the most essential items.

Prices of supplies are increasing. Precautions about AIDS have increased the demand for disposable supplies, a very expensive category of supplies, especially when used in large quantities. Surgical supplies have long been brought from Crown Agents in England. Now, a switch is being made to some U.S. suppliers because of a change in the value of the pound.

One study under consideration to save funds is to use the ECDS for supplies as well as for drugs. But ECDS will require deposit of one-third of the estimated annual expenditures, as it does for drugs. This ties up a lot of money at no interest, but analysis may reveal that the savings will offset the cost of lost interest. It could also show that increasing the reliability of the supplies will increase utilization and overall cost.

Ad hoc approvals and spending constraints mean restricted cash flow, irregular supplies, occasional shortages and outages, and increased unit costs. However, costs are reduced because of the low volume of purchases. Shortages of funds abrogate policies and procedures and enable people to do what they think is necessary according to their experience and judgment. Adherence to procedures could improve these practices, but this will only be possible with stable funding.

Developmental Assistance: Logistics should focus on supply utilization practices, procurement policies and procedures, and inventory management and quality control. This should be followed by the establishment of reserve supplies sufficient to cover a period of time equal to one and one-half times the length of the ordering period for each item.

An action that can improve the utilization of scarce funds is the establishment of a standardization committee. It can limit the number of items purchased, lower costs, simplify maintaining supply levels, and facilitate standardized clinical practice. Purchasing by separate departments should be prohibited both for economic pricing and for sound financial management control.

The assistance for logistics is well understood and readily available. It includes supplies specification, selection, and consumption estimates; storing and protecting stock; standardization committees; and, economic order quantities. It can also benefit from incentive programs for reducing waste and suggestion programs for conservation of supplies.

The curious thing about logistics system technical assistance is how little staying power it has. The system fails because of a lack of financial backing for it; poor supervision of the function by the administration; or, the impact of reliable stock

on utilization. A lack of supplies means conservative, sometimes subclinical, use. Having ample supplies means meeting clinical standards, frequently at a great increase in usage; more wastage; some pilferage; and, some storage losses. These additional risks from increased stocks have to be planned for or avoided.

### **3. Hospital Size**

Dominica has two hospitals, the largest with 189 beds; seven health centers; and, 44 medical stations. One of the hospitals has been recently renovated. The clinics are reported to be short on delivery beds. A recent addition included casualty and ambulatory care and cost 9,000,000 EC plus new equipment. Grenada is completing Phase I of a hospital improvement project, including admissions service and several administrative systems to enhance collections.

St. Kitts has 164 general beds and ten beds for psychiatric patients. Because space is limited, stays tend to be relatively short. This positive situation may change if the new hospital that is being built increases the size from 164 to 250 beds. Nevis has 58 beds, and surgery is sent to St. Kitts. An additional hospital in Sandy Point has 32 beds. Mary Charles Hospital has 10 polyclinic (holding) beds.

The main St. Lucia Hospital is 106 years old and was not designed to do the present functions. The original capacity was 4 beds; now, it has 211 beds. There are three other smaller hospitals.

Developmental Assistance: An American hospital axiom which may apply is: "A built bed is a filled bed." If a country is having difficulty sustaining a low-technology hospital of 164 beds, a medium-technology hospital of 250 beds might be impossible to operate. Some policy makers expect that the increased operating costs of newly built or refurbished hospitals may be offset by additional revenue from private beds if the charges can be set and are paid. However, it is unlikely that a new hospital would attract enough paying patients from inside or outside the country to offset the increased operating costs.

Analysis is needed of the relationships among per capita health expenditures, the ratios of private payment to subsidized care, and the number of beds per population that each country needs and can afford. The present ratios are between 1.6 and 2.4 acute beds per one thousand population. A bed need planning analysis done regionally would help to rationalize this disparity.

### **4. Hospital and Equipment Modernization**

In most EC countries, all capital equipment is owned by the government and located at the largest hospital(s). Fixed asset inventories are rare. Donated equipment, whether new or used, is difficult to keep operating either because of a

lack of training, parts, or biomedical engineers. Often the equipment is the same age as the hospital and declared obsolete by the manufacturer. It may therefore be difficult or impossible to repair due to unavailability of parts.

**Developmental Assistance:** Hospital bed size is a well understood phenomenon. It should be related to population trends, current knowledge about the therapeutic effectiveness and necessity for hospital care, availability of alternative care, and cost. One of the greatest risks to the health system is unneeded hospital beds. They are a cost that never ends. Proper planning for the number of hospital beds needed should be addressed by the persons doing health planning. Studies should be undertaken to look at optimal length of stay, census trends, epidemiology, technology planned, and funding available. These studies could inform the decision maker about optimal size for the hospital if it is to put only necessary and reasonable demands on the health care system.

## **B. FINANCING ARRANGEMENTS FOR PUBLIC HEALTH AND HOSPITAL CARE**

Numerous concepts or systems were reviewed in this preliminary assessment of health financing arrangements; general findings are detailed below:

- **Operating budgets** are reasonably detailed for all fixed obligations such as salaries and utilities.
- **Capital budgets** are specified for very large items. Varying amounts of these commitments reportedly are spent in subsequent years, ranging from 40 to 90 percent. In some cases, large items are carried for several years as capital budget items.
- **Funded Depreciation:** In general, no funds are set aside to replace depreciated equipment. As a result, equipment may be used several years beyond their useful life.
- **Level of Support from Government:** Determination of government recurrent budget funding is usually the balance of funds spent in the previous year, when available, plus a percentage. Increases in funds each year do not match inflation, or the increases in some other sectors where there is less discretion in spending. This is because funding for subsequent years is based on amount spent, rather than amount budgeted. Spending often does not match budgeting because of spending constraints and needs in other areas.

- **Social insurance schemes** are named National Insurance Schemes (NIS) or Social Security Schemes. They do not pay directly for health care services in most countries. Rather, sickness benefits are compensation to individuals for lost income. In some countries, social security (SS) provides a subsidy to the Department of Health. Citizens then use their social security cards at the hospital as evidence of payment for their care. The relationship between the SS contribution to health and the cost of services consumed by SS beneficiaries is not known.
- **Cross-subsidies**, here referring to inflating the price to those who can pay for health services to cover those who cannot, are seen as a mechanism to transfer the cost of non-paid health care from the government to persons with resources. No analysis has been done in the region to determine the usefulness of this idea. It may not be practical because many persons who can afford to pay for care go to the private sector rather than to government medical services.
- **Commercial Insurance:** Some limited experience is being gained by all countries in the uses of commercial health insurance. This experience ranges from lack of sales (due to the absence of opportunities to use it) to utilization rates (which nearly eliminate profits from a portfolio of several policies) to physician fee increases that evoke changing the primary payer from the insurance company to the patient.

Experience with insurance to date has often been profitable due to the lack of frequent large expenditures; avoidance of large expenditures by use of government health facilities; disincentives to use, such as long waiting periods before eligibility for major medical benefits; relatively modest benefit schemes; and, very low payments for government services. Despite these circumstances, some plans, due to low premiums and high utilization, are operating at the margin.

Government utilization studies are not routinely conducted, and commercial studies look only at payment ratios. True actuarial targeted utilization, in addition to age bands, will have to be done if any insurance schemes are to remain continuous.

- **Self-Pay for Medical Care:** The attitudes of citizens toward paying for medical care range from reluctant but willing to outright antagonism, due to historical promises of continuously free universal entitlement to health care.

## **1. Fees, Collections, and Cost Recovery**

The experience in the four countries visited is parallel, with variations as noted. Political tradition holds that the government will provide care. Ambulatory care is provided to the poor by the government while the middle class uses private physicians for ambulatory care. Nevertheless, both use the public system as much as possible to avoid costs. The government systems need more user fees. There is a general recognition that there may be some way for the social security systems to fund a certain percentage of the health system, but this is interpreted variously in different countries. None are yet funding acute care services on a cost-reimbursable basis. The extent to which health programs can be supported through other government taxes is also receiving active consideration in many countries.

Some feel that aggressive action to increase fees and collections needs to be taken now in order to stop the system from failing further. They believe that more analysis can be done once some revenue is being collected.

In Dominica, hospital collections are receiving some attention. Emergencies and discharges on weekends often escape payment because of staffing. There is recognition that people are not interested in paying because they have never had to pay and may not have been aggressively informed of the government's expectations that they now have to pay. They may also feel that their payment is insignificant because what they receive is so great in relation to the fee. A recent health sector report (Mcintyre) which recommended raising fees was considered by the government and put on hold pending more information.

In Grenada, revisions of user fees for hospital rooms are now before the legislature. A revision of the system for paying for surgery at the hospital is also being considered. Desirable features of the proposed fee change are: a formal collection mechanism; a pre-specified allocation of fees; a possible set-aside from the consolidated fund so that fees are not lost to the health system; and, a role for the District Medical Officer (DMO) as gatekeeper.

In St. Kitts, fees at the hospital have not been raised for years, yet demands for service increase drastically. People pay next to nothing, at most one or two EC per day. Fees need to be brought in line with actual costs in order to maintain and improve the level of services.

In St. Lucia, financing options focus on the National Insurance Scheme (NIS), which could be incorporated partially with private insurance. Establishing an identification process requiring a card from NIS, the farmers' association or another source is planned. People who are not members of associations and who do not have access to an organization will fall in another category of government responsibility for which a mechanism is still to be selected.

Developmental Assistance: Establishing systems for the hospitals to do their own billing and collections will require establishment of a sliding scale for patient fees. The governments will need to acquire expertise in developing fee structures and designing systems and procedures to recover costs of the various services offered by their subsidiary facilities, including pharmacy, outpatient care, in-patient care, and auxiliary health services.

Technical assistance also will be needed to establish costs per unit of service. These may be based on some ratios of departmental inputs and departmental production output statistics or other measures. Equity should prevail, and there must be a sound basis for assuring that fees can be raised realistically, perhaps gradually, to reflect current and increasing costs.

Analysis of the various options is necessary. But the assistance, in whichever form, should be regional, institutionalized, and accepted in principle, or the initial struggle will have been wasted. See discussion of "Political Will" below.

## **2. Dispositions of Funds Collected**

In all four of the countries visited, the hospitals have made some progress in collections of fees. Some hospitals are more organized than others, but none is entirely systematic. All are trapped by their need to collect fees to operate, the users' reluctance to pay, and the governments' reluctance to charge. In all countries, any revenue collected is remitted to the consolidated fund; no country gives hospitals the authority to use fees collected to finance operations. In one country where the hospital is allowed to keep the money, its expenditures are reduced through outside management of other expenditures.

Developmental Assistance: This topic also is related to the issue of political will and to the principles in the general recommendations listed in the Executive Summary. Assuming the general principles are accepted, it will still be necessary to establish relationships to make them permanent. For example, it will be necessary to establish a liaison for hospital financial functions with the government financial departments to expedite information and transaction processing. The present separation of the Ministries of Finance and Health mitigate against this, but this must be overcome by sound institutional and organizational development. Regional models may be useful here as change agents. This discussion is related to the topics of new hospital governance structures, independent hospital boards, stewardship of public funds, and the risk of government abdication to such boards.

### **3. National Health Insurance**

In Caribbean countries, when a government finances health care, it considers funding the cost through a system such as their social insurance program. That is, the government will ask for a certain percentage of wages to fund the coverage. A national health levy of another two percent would generate a substantial amount. This option is appealing to the governments because of its past success. However, a careful plan would be necessary to determine what portion of health care costs this would cover.

Alternatively, as in St. Kitts, there is some discussion that the social security scheme may be tapped for health care. The Prime Minister is the Chairman of the Board of Directors for Social Security. It was reported that PAHO had agreed to help with a study of how the national (social) insurance scheme could help finance the health system. A major commercial insurance company is a subsidiary of the National Bank and Trust, which is fifty-one percent owned by the government. It will soon provide a health insurance policy for all government employees.

A typical example of the way the social security system supports the health system at present is found in St. Lucia. Fire, police and nurses are entitled to NIS benefits. These benefits do not pay for medical services directly but for time lost from the job due to illness, maternity or disability, and some death benefits. No one else who is working, including other government employees, is covered. Ninety percent of civil servants are not eligible. Analysis is needed of the management ability and actuarial basis for the NIS to administer a national health insurance scheme.

The small state economies are getting past the stage of ad hoc health care financing. At the same time, private employers are becoming more shrewd. They will not volunteer to play a major role in a national health system. Work needs to be done in developing ways for the government to monitor the contributions of employers and employees. The government may have to set minimum standards to protect itself, the public and the sick. At the same time, the role for the private sector must prevent fueling more health care costs.

The Medical Association is in favor of and has encouraged the government to look toward a national health insurance scheme.

**Developmental Assistance:** National health insurance schemes are not likely panaceas for the national health care financing issue. There are too many unknowns concerning the cost and management of such plans. The most likely role for government in a national health insurance plan is that of referee. What it would need to know to put legislation in place has not been learned for countries the size of those in the Caribbean. What is clear is that it is imprudent to recommend a

massive government contribution. It represents an extreme burden that could only be considered with intense utilization control. Some assessment of the potential in various countries by a qualified and experienced insurance economist with an actuarial assessment would illuminate the extent to which some form of universal coverage could be sponsored by these governments.

#### **4. Commercial Insurance Coverage and Utilization**

When commercial insurance was first offered in Dominica, 300 claims per month were processed. There was no deductible and doctor visits were paid with no limits. Because of overutilization by subscribers and increasing charges by providers, private insurance is no longer sold. Also, insurance companies began paying the beneficiary rather than the doctor to slow fee increases.

Group policies now provide coverage for overseas treatment. Services available in Martinique are preferred even though the prices are very high. Three thousand French francs per day is the cost of intensive care. The charge for routine hospital care is 2000 to 2500 FF per day.

Presently, there is little incentive to buy private insurance. People who have insurance cannot use it effectively. Commercial insurance is considered unattractive because subscribers receive the same level of care as non-subscribers.

In Grenada, there has been a dramatic expansion of health insurance coverage, both for private insurance plans and for government insurance schemes.

Typical health insurance benefits do not pay for outpatient care or doctor visits. Rather, they pay only for hospital care at a rate of 50 to 600 EC per day for 90 days, or until a ceiling of 54,000 EC is exhausted, once a year. Some plans pay per day in the hospital. Some group schemes cover part of doctors' office visits or part of medication. This market has not yet been sufficiently developed for products. Some offering could be provided at a reasonable cost, if the risk were shared by consumers. Small monthly contributions might work.

Some insurance plans from abroad were tried in Grenada. They did not succeed because their costs were too high.

In St. Kitts, the national bank, in which the government has 51 percent of the shares, holds an insurance company which will soon provide insurance to permanent government employees. Ten percent of the labor force is now covered by commercial insurance, and the anticipated addition of the government employees under the new plan will about triple this number. In general, many people do not buy insurance because the government is unable to provide them with any services

that are not provided free to others. Thus, insurance primarily covers surgeons' fees since doctors' fees are free.

In St. Lucia, there is sufficient experience with commercial insurance funding and claims that some retrospective analysis would be informative. Wide fluctuations in utilization within and among groups indicate that individuals hold widely disparate views about what access to care should be assured by purchasing an insurance policy.

The Medical Association has encouraged the government to look toward a national health insurance scheme. It recommends consideration of the contribution mechanism administered for the NIS for health care because of its experience with the administration and collection of insurance funds.

A possibility has been identified for commercial insurance companies to be the intermediaries in a government-mandated insurance program. Their fee for management and an agreed-upon profit could be negotiated. Incentives could be offered to the intermediary for effective management and control of utilization.

**Developmental Assistance:** There is a rich opportunity for some expertise to be applied at this stage in the development of insurance products. A policy issue is whether the system should be private, governmental or parastatal. Different interests would favor different types of analysis of this issue. Analysis can be used to identify the roles of various funding devices in a system where costs are shared by the government, social security, commercial insurance, and self-pay, and where no costs are paid by the indigent or medically indigent.

## **5. Social Security Funding of the Health Services Systems**

There have been discussions throughout the Caribbean countries about opportunities to make changes in social security to provide health care services. Directors of SSAs and Ministers of Health have participated in these regional meetings to discuss medical care financing. It was reported that PAHO has agreed to help with a study of how national insurance schemes can help finance the health system.

In Grenada, the social security scheme resembles that used as a general pattern throughout the entire EC. It was formulated according to International Labor Organization (ILO) and United Nations Development Program (UNDP) recommendations found in the Eastern Caribbean Multi-Island Report. Benefits are not paid for direct payment of medical care. Rather, the fund provides payments to persons who are unable to continue their employment for a variety of reasons, such as maternity, old age, invalidism, sickness, survivors, and grants for funerals.

An actuarial consultant has advised the NIS that, based on the experience of other countries, it is financially capable of providing coverage for occupational hazards and injuries. These benefits could begin as early as next year.

As far as other support of the health system, as in other EC countries, the NIS may be willing to make some capital contribution to the health system. The use for the funds that was identified was assistance in the building program of the hospital.

In Dominica, there is confusion among the populace and some government officials about the role of the social insurance scheme in health care financing. There are conflicting attitudes that social security beneficiaries should be exempt from all fees versus the feeling that their fees should be paid only to the extent that the transfer payment covers the cost of their care. Citizens and SS staff have an exaggerated conception of the amount of health care SS actually pays. Education is needed for all parties as part of an overall program to inform people about health care financing options and their responsibility to provide for their own care. For example, many subscribers still use their social security cards instead of their commercial insurance, even in cases of insurance physicals.

In St. Kitts, the social security system makes no annual contribution to the health care system but will buy specific items as requested by the hospital. The SSA has provided a facility for the drug unit, and \$100,000 (US) for hospital lab equipment, mammography, and a portable X-ray. At this time, capital contributions are the only funding source. It would help those responsible for financial management of the hospitals if such contributions could be made on a predictable and/or regular basis.

In St. Lucia, a reserve of two percent has been set aside for the Ministry of Health (MOH) since the inception of the NIS, which includes 20,000 registered persons. This suggests there is a sizable fund for an undetermined MOH use. There may be some restrictions on use, such as authorizing support of hospitals but not of health centers. There are many potential uses for these funds, including but not limited to: new construction, new equipment to slow the outflow of dollars to pay for services received at other islands, training, investment in selected certified cost reduction strategies, or as reserves in a new indemnity plan.

The scheme is funded by a contribution of five percent from employees and five percent from employers. A subvention of 1.5 million EC is paid annually by the NIS to the MOH. There is a focus on NIS as a source for funding a health insurance scheme, and a parastatal model in cooperation with private insurance has been considered. There is awareness of the necessity to provide coverage for the medically indigent, the ability of various groups to purchase health insurance, and various ways to incorporate the privilege of the farmers' unions in light of their tax-free status.

The medical association is in favor of some kind of national health insurance scheme and it has encouraged the government to look toward such an activity. It recommends the consideration of administration by the NIS because it has a financial administration system of collections and disbursements in place.

Developmental Assistance: Social Security financing and/or funding of health services is a major concern in all the countries visited. Some opportunities are seen in the experiences above. Technical assistance would be useful in understanding the impact of commercial insurance on people's behavior and vice versa, and could result in improved utilization and parallel improved benefits or reduced costs. This information would also be used actuarially for a state-sponsored plan. The government's taxing authority is sufficient to assess revenue. Previous social insurance plans have generated large reserves in some countries. In some cases, the funds are used for services for which they were not originally collected.

## **6. Charges to Non-Nationals Receiving Medical Services in Country**

In the EC countries, there is some awareness of the extent to which people may move from one island to another to obtain health services. This occurs because of lower costs in other countries, or because of lack of services locally. There is a widely held belief that all of the countries have an opportunity to increase revenue from foreigners by having a set of non-resident fees. There are no estimates of potential revenue or of present losses. In Dominica, people now come for obstetric/gynecological care from Antigua, Montserrat and elsewhere, and the hospital administrator there has presented a request to the MOH to initiate increased fees. In St. Kitts, non-nationals pay double for room and board, and other fees also are billed at higher rates. Fees for CAT scans in Antigua have recently increased substantially, as that country has become aware of its operating costs.

Developmental Assistance: There are several categories of persons from outside the country for whom there is a basis to establish alternative fee schedules, in addition to different fees for citizens based on their ability to pay. Some of these groups are tourists who have ample insurance and those who come from other countries to obtain low cost care or to obtain care not available in their country. Separate pricing strategies could be used for these groups and others. Systems to bill and collect from foreign nationals or other persons having medical insurance coverage should be implemented. Technical assistance can be obtained from the experience of third-party billers in the United States, United Kingdom and others.

This is an opportunity to introduce discussion about sharing high cost services to regional policy makers. Regional planning or individual agreements could be established to prevent health systems from being exploited by their neighbors. Regional eligibility criteria could be established. This would overcome some difficulties that exist because of the amount of migration among the island countries.

## 7. Implementation of Regional Systems

There is currently an opportunity to develop health systems efficiency and accountability through regional planning. Areas where regional cooperation would be useful include:

- Medical services. For example, Barbados was the only center for radiotherapy in the region until Antigua began providing this service. Initially, Antigua was providing the service at a low cost, but it subsequently found that maintaining the equipment and providing supplies increased costs.
- Management systems. Implementation of a standard chart of accounts is a prerequisite for the development of a regional cost accounting system. It would be reasonable to recommend one for OECS-wide consideration.
- A regional approach to some type of insurance plan could be developed.
- Medical equipment purchases and planning or cooperation on a regional basis would have a salutary effect, but would face difficult circumstances. Standardization of equipment would be desirable for maintenance and training, but different country donors provide different equipment to groups of islands with different political associations. Cooperation is possible among groups of islands, for example, Montserrat, Antigua, St. Kitts, and Nevis.

The role of intergovernmental cooperation is under development, and a model agreement could be formulated. The association of opposition political parties is active in considering health issues.

Developmental Assistance: Regional policy assessment, training and recommendations could be fostered through policy analysis workshops. An interesting planning model could be developed that would phase the implementation of an overall regional project by pulling in significant parts of the effort from the strongest aspects of the different countries. The mechanism by which services would be provided for the indigent and the medically indigent makes this issue more difficult especially because this problem has not yet been effectively addressed in single countries. Decisions will reflect consideration of respect for individual needs and protection of government health system resources. Any model will have to be approached incrementally. Design of such an effort can be part of a regional policy dialogue/social marketing approach.

## **C. DEMAND FOR CARE AT VARIOUS LEVELS**

In circumstances where governments are aware that the need for health care services in their country exceeds their ability to pay for services, it becomes necessary to do a detailed assessment of the financial structure of the health sector. Information obtained is the basis for assessing the effectiveness of various approaches to financing health care services. However, government data frequently are not readily available in a sufficiently disaggregated form for analysis.

Individual expenditures must be obtained through surveys of individual behavior, conducted either at health facilities or at households, depending on the information sought. Household surveys give access to wider segments of the population and provide information about illness for which care has been sought from any provider, or for which care may not have been obtained either through hospital or ambulatory care, in all areas of a country, from all types of providers. Full analysis of the data obtained may enable health planners to understand the effects of changes in health care financing that they may be considering.

### **1. Demand for Health Care Services and Government Policy**

There is general awareness that the level of demand for health services reflects people's perceptions of many aspects of health services. Policy makers are aware that improved services will bring about increased demands for care, and that there are both conscious and unconscious elements of people's perceptions of quality of care. Authorities do not want to increase demand to the highest level that their country can afford, which would lead to unnecessary utilization. To control demands on the system, planning and long-term financing strategies must be formulated with due consideration to ensuring that the needy are not disenfranchised.

In St. Kitts, demands for service are increasing drastically, and fees need to be brought in line with actual costs. People now pay minimal fees and it was remarked that providing a receipt for fees costs more than the amount of revenue received for the service.

Administrators in St. Lucia are familiar with demand studies and they are concerned with how people perceive the health care system. They realize that efficiency of services is of limited use in increasing ability to respond to demand, and that the utility of cost recovery depends on how much you can provide with what you recover. Also, a fee imputes a value and is also a deterrent to use. Demand is related to the confidence people have in the system. If facilities are not available, demand is not a real issue. Services will have to be paid for if they are to be made available.

Developmental Assistance: Demand studies will have several purposes. They are useful for establishing standards of care, costs of services and program effectiveness. In addition, they are useful both before and after public education programs about the costs of health care and can provide guidance about the acceptability of fee revisions to the public. Demand studies are needed to discover the number of people who require care but are too poor, disaffected, alienated, or uninformed to seek care. Analysis of demand could provide economic justification for capital equipment purchases. Demand studies will also influence policy choices. For example, demand studies can assist in estimating the amount of subsidy required to maintain a predetermined level of services.

Household-based studies of demand for health care are a basis for determining 1) the health status of a country, 2) whether and where people obtain curative care, and 3) how much they pay. Demand studies may either merely record individuals' health-services-seeking behavior, or they may obtain data to explain the behavior. It is generally cost effective to mount the more informative model. The marginal cost is small since the largest part of a demand study is the survey process. However, the level of analysis needed to explain behavior is more demanding. Unless the analysis and the questions are carefully framed prior to the survey, the additional information may not be more useful to policy makers than the data on behavior without causality explained.

In the Caribbean, demand studies, if undertaken, should be framed to provide comparative data among all countries surveyed. A major study across all islands at one time would be the most effective way to get comparative data, assuming the survey was well conceived and exhaustive. Some pilot studies might provide information for the design of such a major effort. The result would be that each country's health program would be described adequately to enable local and inter-island understanding.

Health characteristics for each country should be made compatible with a common Caribbean health data dictionary, which should be developed prior to any demand studies being conducted. Topics should include the services of a fully developed health care system, such as:

- maternal/child health-care;
- immunizations;
- accident prevention; and,
- public health services,

as well as education about:

- nutrition;
- sanitation;

- substance abuse (narcotics, alcohol and food);
- sexually transmitted diseases;
- family planning; and,
- treatment of acute and chronic diseases.

## **2. Ability and Willingness to Pay**

An issue in the EC states is how to convince the population that they have to pay for health services. Politicians have long claimed that they will provide free health services. However, the people are aware that health services are deteriorating, that nothing is free, and that the governments cannot pay for all the services despite the physicians' claims. Also, people are aware that available health services are not always as comprehensive as they would like to receive. They feel they are paying nothing and getting a bad service. Those who can afford it would pay more for a good service. In some countries, people are becoming accustomed to paying small fees. Now the fees must be increased regularly to sustain the health system, but related to ability to pay.

In some countries, efforts to collect a deposit are now made on admission to the hospital, but not all patients pay. Follow-up policies and procedures are not consistent. Also, payment is lost when ambulatory surgical patients report to surgery, are treated, and leave with no record of having been there. On the other hand, there is sometimes confusion about what happens when fees are paid to the hospital. Patients have complained that they pay the hospital for surgery and that they have to pay their surgeon as well.

Private doctors provide some free care to people who cannot pay, but they are also not aggressive about collecting fees from patients who fail to pay. Emergency surgery patients are not billed by the doctor if they cannot afford to pay; elective surgery waits until the patient can afford it.

In some countries, ambulatory lab work is not performed without payment unless the person is unable to pay. Fees collected for this work are very low. When the fees are raised, more people will be unable to pay. On maternity, there is no problem with fee payment; all patients pay their obstetrician. A lower fee is paid to the obstetrician if the delivery is performed by a midwife.

Developmental Assistance: This issue will be best addressed through education of the policy makers and the population. There are different degrees of willingness to accept the responsibility for paying for care in the different countries visited.

This willingness ranges from grudging acknowledgment of the inability of the government to continue to pay to absolute refusal to accept that health care is not the exclusive responsibility of the government.

Many of the respondents believe that the prevailing attitude is denial. All citizens know that their government has limited resources and that health care is becoming increasingly expensive. Many of them know it first hand either from paying for private diagnostic services in their own country or from purchasing hospital or ambulatory care in other countries.

The current lack of will by politicians to impose fees is ironic if it turns out that they continue to disable their health care systems because they think people in their countries believe their promises to do the impossible. The politicians think they are fooling the people when actually it is the people who are fooling the politicians. As long as the people continue to pretend that they believe the government can provide them with free health services, the politicians will believe they have to do so. While this ritual continues, the ability to provide any health services continues to decrease as capital is consumed for operating expenses through not funding depreciation; and the cost of providing basic health services increases faster than the revenue base.

The most useful technical assistance in this area is education and social marketing. Making the movement a regional one may be a way to insulate the local politicians from bearing the brunt of the imposition of reasonable fees.

### **III. INSTITUTIONAL SETTING**

Technical assistance to promote financial sustainability could be provided effectively through strategic planning retreats for politicians and senior health care managers. The purposes of these retreats would be to:

- Develop understanding of the purposes and processes of local planning and regional cooperation;
- Increase awareness of options; and,
- Develop the capability to initiate action.

## **A. CAPABILITY TO IMPLEMENT MANAGEMENT IMPROVEMENTS**

The areas in which technical assistance can substantively improve management awareness and performance are listed here. They are also prerequisites to having effectively managed health systems.

- Organizational development
- Personnel management
- Strategic planning
- Human resources
- Logistics
- Admissions, transfers, discharges
- Collections

### **1. Essential Management Improvements Needed**

In Dominica, some work on policies, quality assurance, patient classification, and nursing policies is being provided by PAHO.

In Grenada, renovations and the development of a hospital admissions suite will provide an opportunity to learn to control admissions and collections, and to support the development of medical records. The development of an admissions service is an opportunity to fully develop the financial controls for both inpatient and outpatient procedures for centralized and off-site services. This effort, which is being paid for through a grant from PAHO for hospital management improvement, is also focusing on medical records.

The Department of Personnel and Management Services is in the process of revising position descriptions. Hospital policies and procedures have not yet been modernized. Policy guidance is in the form of statutory regional orders. A nursing policy has been initiated but there are no policies in other departments to which it can refer.

In St. Kitts, hospital policies and procedures are found in the Hospital Regulations 1968, No. 40. The absence of modern policies and procedures enables people to do what they think is necessary according to their experience and judgment. Improving the structure of the system calls for policies and procedures, supplies, forms, and training. Nursing is engaged in the development of additional systems and

procedures and is actively developing close working relationships with the doctors. However, without adequate funding, this process will do little to improve the range of services offered or the quality of care.

In St. Lucia, a new administrative leadership in the hospital is trying to revamp hospital attitudes by making some strong administrative decisions. The focus is on training people to be part of the system. A first effort was with the orderlies, who now have a supervisor and a job description. This has created some conflict with nurses and doctors who are not used to orderlies who have and accept responsibility. The services have improved but the role definition has to be undertaken for all position descriptions as soon as practicable, accompanied by the development of policies and procedures for people to follow. These are the most fundamental organizational building blocks.

Aspects of hospital management which are under development include the management structure; procedures and manuals; admissions, discharges and transfers; alterations to inpatient flow; and, computerized medical records. PAHO has provided assistance for much of this work.

**Developmental Assistance:** Management assistance is needed to rationalize the basic management structures, including setting politically acceptable and realistic fees, learning actual costs, continuing development of hospital management systems, developing billing and collection systems, conducting staffing and task analysis, developing quality control and quality assurance programs, and staff orientation training and in-service education.

The hospitals now operate with ledgers and logs that are used only as short-term paper information records. Data are compiled primarily by the medical records departments or accounting departments for hospital statistics. None of the other data routinely collected in the hospitals is used for any management purposes. Information needs will have to be identified in stages with data collection forms and procedures reviewed and revised as needed. Also, data processing will need to be progressively automated but only so far as is necessary to have some systematic use of information for managerial and technical decisions. Information needs will include vital statistics, service statistics, program and service costs and, eventually, staff productivity. Ultimately, it will be useful to train hospital department heads in various management practices using simple data, such as ratios, rates and indexes. They can be used to set criteria for assessment of departmental performance.

## **2. Training for Staff to Enhance Capability**

The training that is needed in the health systems of the EC countries is typical of any health system. Below we have listed some ongoing activities and aspirations

found in the various countries visited. Everything that is reported for any country is equally necessary in all EC countries in order to develop effective health systems.

In Dominica, there is a major effort to train nurses in family planning counseling, sexually transmitted diseases, women's health and adolescent health counseling, and reproductive health. There is also work being done in standardizing the staff development program, public health nursing and family nurse practitioner training.

In Grenada, patients may report to surgery, be treated, and leave with no record. This is a situation where a procedure with adequate controls and training could eliminate a problem. A similar situation exists in the ophthalmology service where collections lag because the sight treatment center is too far from the hospital.

In St. Kitts, training is needed in management systems in order to enable the hospital staff to make the best use of available resources. Maintenance program training is needed, including training and preventive programs. The support staff is skilled and flexible but more training is needed to improve their skills. Quality assurance programs will require training in the structure, process, and outcome of health care processes. Budget training is on-going.

St. Lucia needs additional computer training. The nurse practitioners are trained by PAHO in St. Vincent, but some have recently gone to Jamaica for needed long-term and short-term training.

Developmental Assistance: The need for training in any environment is nearly endless. The task for the health financing project will be to limit its efforts to the areas that are directly related to its goals, since nearly all aspects of the health system are related indirectly. Some courses in the highly technical aspects of accounting and information systems and planning and management may be all that can be justified. It will be a matter of funding levels and priorities.

### **3. Need to Rationalize the Financial/Budgetary Process**

Purchase of capital equipment is severely constrained by high cost and lack of funds. Typically, a plan is made in the budget estimates to purchase equipment. Funding delays then occur so that some items are carried for several years before they are purchased. Over time, costs may increase more than the cost of interest on funds to make the purchase. Alternatively, the useful life of the new object has not yet started so later expenditures are further delayed. Since some borrowing is always done, not borrowing for the postponed item indicates a prioritization process for national spending. These observations begin to describe a model for health care funding that presents an opportunity to make explicit and analyze some observed behavior.

Some hospital and ministry staff reported that they are not in control of the budgets for areas where they are responsible for service. Increased involvement in budget implementation could partially relieve people of the belief that they are not in control. Complaints were noted that funds are budgeted and available but are not spent for needed supplies. Budget committees in each ministry make estimates based on previous expenditures. If a department did not spend their funds the previous year, their estimate is reduced.

There are several bureaucratic impediments to orderly spending. The systems now operate in a condition of precarious homeostasis. A balance is maintained between near shortage of supplies and funding periodic allotments. Ad hoc approvals and spending constraints mean restricted cash flow, irregular supplies, occasional shortages and outages, and overall reduced cost. There are several bureaucratic disincentives to effective hospital management. All are functioning government cost optimizing strategies. It would help managers if these strategies could be made explicit. But that would require some direct honesty that would challenge the current allocation process in all the countries.

**Developmental Assistance:** Budgetary knowledge is needed particularly for hospital operations. However, the process without the political commitment is useless. Aspects of a budgetary process would include:

- Increased knowledge of budgeting as a planning and control technique;
- Increased awareness of the need to maximize the results and benefits from limited resources;
- Increased knowledge of techniques for cost reduction and savings;
- Systematic coordinating of forecasts comparing these estimates against actual results; and,
- Accurate information for planning and reporting.

Financing and cost accounting systems should be designed for planning, controlling and evaluating the financial operations for the health sector at the national level. Systems should be designed so that they may be applied at all departments as well as regionally. Cost accounting systems should be designed for both manual and electronic operation. Management could also be educated and assisted by adoption of a method to categorize costs and implement cost ratios using a set of departmental ratios such as those provided by the Monitrends service of the American Hospital Association.

## **B. INTERVENTIONS NECESSARY TO PREPARE FOR STRUCTURAL CHANGES**

Technical assistance dealing with social and political concepts includes several areas of organizational/structural change, including political financial leadership and responsibility, consensus building among politicians and the populace, and education of the populace about realistic assessment of costs and about the willingness/necessity to pay for health care.

## **IV. COST ANALYSIS FOR CAPITAL ACQUISITIONS**

In general, there is no routine analysis of the impact of capital investments on recurrent costs, no cost-benefit analysis, no comparative analysis of the uses of capital, no comparative cost analysis of obtaining services out of country with capital investment, and no consideration of strategies for incorporating fees for new services. Capital expenditures are generally funded from surplus funds. Because there is usually no sizable surplus, there have been only limited capital expenditures.

An ultrasound unit is being bought by local practitioners because they are currently better able to fund the cost of sophisticated technology than the government.

Developmental Assistance: It will be necessary to:

- Establish funding of depreciation to assure the replacement of capital equipment as needed and the ability to equip planned new services. This assumes that the cost recovery strategies are sufficient to stop using capital for operations.
- Establish a capital funding plan with appropriate cost analysis measures to assure continuation and expansion of programs.
- Develop a capital spending plan based on age of equipment, medical need and clinical program planning.

## **V. HEALTH POLICY FRAMEWORK**

Prerequisites to the revision of a health policy are interest, capability and willingness. These factors are often constrained in a political setting. Impediments to the development of informed health policy include:

- Technological fascination and/or infestation;

- Underutilization of the national intellectual capacity because of:
  - Insufficient training,
  - Out-migration,
  - Political job assignments,
  - Inappropriate job rotations,
  - Uncertain management direction,
  - Bestowal of privileges,
  - Lack of capital, and
  - Instability of financial commitments; and,
- Need to implement management improvements and structural changes.

Improvements and structural changes are most often initiated according to the need for the change, demand for the service, ability to garner resources, existence of predecessor events, and interdependencies with existing programs. Impediments to necessary change may be political opportunism, lack of determination, political opposition, and incomplete strategic thinking.

## **A. CHANGES NEEDED TO IMPLEMENT MANAGEMENT AND STRUCTURAL IMPROVEMENTS**

### **1. Legislative Action/Political Will**

In all the countries visited, there is discussion of raising fees for services, but at least some demonstrated reluctance to do so. In Dominica, hospital fees are the same as when they were instituted more than five years ago. Health care financing actions were expected from the legislature this past June or July, but now are being postponed until the next session. The opinion was expressed that fees cannot be raised without knowing what the other islands are doing because the countries are too close together.

In Grenada, the legislature is considering a revision of the system for paying for surgery at the hospital. Previously, there have been complaints from patients that they have to pay the hospital for surgery and they have to pay their surgeon as well. While this is customary in a fee for service society, it is a reasonable complaint in a society where the persons have been raised on an expectation that there will be free service from the government for their health needs. The policy change which has been selected to address this issue is a legislative change in the hospital fee structure and the allocating of these fees. The proposed law would assign a levy of 500 EC to be divided half and half between the hospital and the attending physicians.

In St. Kitts, a question was raised about how private doctors should compensate the government for the privilege of using the hospital for their procedures. Collecting a fee from the doctors should evoke some caution. It appears to be a dubious way to finance the health care system since the country sometimes has difficulty in filling consultant posts.

Governments do not have any expectation that they will be able to raise fees to a level approximating the actual cost. However, an interim step is to devise different cost alternatives based on access to services that persons with various income levels will be provided at government expense.

There is also an increase in chronic diseases and some awareness that if the governments cannot devise a method to fund services, then people who could live if they received medical treatment may die without it.

It is also of concern that if the facilities are improved and services offered, the demand may overwhelm the system providing the service.

**Developmental Assistance:** Refusal of politicians to make risky political decisions is described by persons who do not face such risks as a lack of will. The will required is to inform the population that in the future they will be required to accept the burden of paying for their own care to the extent that they are able. There is clearly a savings to the government if the community is disaffected with its health care system. People who do not present themselves for treatment are low-cost patients. This may be a very large group. In this case, they represent a substantial savings for the government. Often, the diseases for which they do not seek care are self-limiting. Other than the discomfort of a temporary affliction, there is no cost. However, other scenarios exist. In some cases, persons who have serious discomfort avoid treatment. In other cases, persons fail to get treatment for a symptom that may not cause discomfort but may be indicative of a more serious medical problem.

## **2. Government Attitudes Toward Universal Entitlement**

Government attitudes toward universal entitlement in a particular country depend on the political philosophy of the government. Some discussion focused on the nature of ordinary medical care versus extraordinary medical care, and on the use of this distinction in describing government responsibilities and the role of commercial insurance. These issues hinge on the extent of government assurance of entitlement to health care, resources available, and the ability to fulfill its promises.

In the EC countries, there is much discussion and interest in financing the health care system. There is indecision about whether to make changes at the present time or in the future, which reflect political considerations. There is awareness that fees at hospitals and clinics must be increased. However, this has to

be done in the context of governments having long promised free access to health care.

The public expectations from the health system are increasing as a result of television, especially the cable health channel. The demand is increasing for upscale health services for acute and chronic diseases. There are also increasing expectations for privacy and confidentiality. This is a challenge to the government because it cannot afford these services but, politically, it cannot afford to ignore increasing expectations for services. The time may be approaching when pressures on the health care system may make it more politically realistic to educate people that they will have to pay for health services. This is a change from the myth that care can be provided by the government for free. Policy analysis and discussion with politicians is necessary to explore options. These issues can be addressed through education and social marketing.

**Developmental Assistance:** There is a need to discuss access issues in the context of the consequences of inaction. The governments have long resisted increasing fees because of the political consequences. It has been suggested that the time is approaching when the political consequences of inaction may be more serious than the responsible action of raising fees. Useful analysis could be done on the cost of providing health services to people who may not receive appropriate and timely interventions and who therefore may require expensive treatment.

If governments continue to decrease funding for health care services, both the quality and level of care are compromised. Issues of access and equity could reasonably be discussed in the context of preservation of the existing system by avoiding bankruptcy.

### **3. Health Planning**

The budget of few countries can provide the entire amount of health care that could be used by all the people for all levels of care. Therefore, it is necessary to plan to allocate state and other funds to provide the optimal benefit to all population groups. However, in the countries visited, there is no common uniform data base for planning. Hospital statistics have not been recorded for the diagnoses and other data needed for planning. Such data are necessary to develop strategic plans for hospitals, including the development of methods to contain costs and increase revenues.

As the health care sector experiences reductions in its funding, targets for cuts may be some underutilized primary care services, such as hospitals which are higher cost and less conveniently located. There is already some feeling that some services that could be provided at health centers should bypass the centers for treatment at the hospitals. An example is the number of deliveries at the hospital which could be done at health centers. There are several reasons why primary care clinics are not

attended by the populace. One is that they are not attended by the doctors. There is some absenteeism, or short attendance at work, by district medical officers who staff the government primary care clinics, sometimes in competition with their private practice.

The diffusion of medical technology is largely restrained by capital. There has been no analysis of the efficacy of expensive new technology as opposed to obsolete non-effective technology, such as the use of CAT scans for traumatic head injury versus the use of skull x-rays, pneumoencephalogram and open brain surgery.

**Developmental Assistance:** Technical assistance in the process of health care planning would enable local policy makers to have a structure within which to set priorities as well as the ability to rationalize necessary decisions, such as program decisions in regard to resource allocation between primary and secondary care and capital budget decisions.

Without a system to record the activities of each hospital or health ministry department, it is difficult to do routine planning. Such a system should have methods to record the following:

- Inputs, which may be in the form of demand for services, resource requirements, personnel, equipment, and supplies;
- Processes, which may be in the form of scheduling personnel, scheduling tasks and procedures, or obtaining equipment, parts and supplies; and,
- Outputs, such as tasks performed by hospital support departments, tests or examinations performed by diagnostic departments, and treatments provided by therapeutic departments.

The development of the planned data system is necessary to enable health care planners to group the population by age, sex, disease category, ability to pay, health conditions, and ability to provide self-care. These characteristics and others determine estimates of the resources an individual or a group will need to maintain their health.

## **B. STRATEGIES TO ENHANCE PROSPECTS FOR CHANGE**

There are several possibilities for a generalized type of technical assistance that are very appealing. An opportunity to increase efficiency in the development of health care systems is to offer to provide the same sequence of technical assistance to all countries of the EC simultaneously. This must be done with full respect for the

sovereignty and uniqueness of each country. Each country would implement a standardized methodology according to their dictates. If all countries can be involved in the development of the methodology, the probability of accepting it will be increased.

Each country's health care program goes through phases that are later reflected in their health care policy. Changes in each area can occur at any stage in the development--during initial planning, implementation and/or operations. One set of steps that would produce a sound health care system with an informed policy base is listed below. However, programs rarely evolve in such an orderly manner. Therefore, technical assistance will address various issues among these, in whatever stage of development they are found.

- Determination of basic program requirements
- Determination of basic financial requirements
- Capitalization
- Estimate of demand for services
- Program development
- Guarantee of access
- Privacy
- Confidentiality
- Equity
- Staffing
- Training
- Marketing
- Operations
- Adjustment to market response
- Demand stabilization
- Affiliation and integration with other programs
- Maturity
- Utilization review
- Evaluation

The known responses of a government or its ministry of health to this list of steps, whether written or unwritten, constitutes its health care policy. Examples of how some countries respond to these issues are listed in the following sections. The lack of an extensive set of examples demonstrates the state of formal health care policy development in these countries. One conclusion that could be drawn about the absence of well-articulated policy is that policy is easier to make than to revise. However, the policy may exist even though it is unwritten. In this case, the strategy of parallel simultaneous development referred to above may be the preferred change strategy to achieve progress in health care policy in many countries simultaneously.

## **1. Regional Training**

There is substantial willingness to pursue technical cooperation for medical services in the region. Such cooperation and understanding are needed for regional systems development. In Grenada, regular meetings of managers of the regional social insurance schemes have discussed their role in regional health care. There may be more nay sayers than visionaries at this time, but the pendulum is swinging toward their regional involvement. There has recently been a spirit of cooperation emerging among young doctors and a pooling of effort to establish a good medical service.

Awareness of the advantages of regionalization in Dominica is developing from awareness of the cost of emergencies, orthopedic care, cancer care, and burn cases which are sent to Martinique, Guadalupe, and Barbados.

Regional cooperation among affinity groups of islands may be suggested as a step toward regionalization or as an alternative. The necessary cooperation could be encouraged by legislation, with adequate protection assured.

Developmental Assistance: Respect for sovereignty and uniqueness would not preclude the opportunity to train people from several countries through a series of joint meetings. This could be done in the context of institutional strengthening for the whole region.

Technical pieces developed in different countries can be transferred to other countries to reduce developmental costs. This could have the added advantage of providing regional data comparisons across countries.

## **2. Public Education Programs**

There is recognition of the need for much work on public relations to increase understanding in the populace about the health care system. Education should be directed toward eliciting appropriate responses concerning personal responsibility for health care and realistic understanding about the extent to which governments can continue to support all health care costs.

Health education could include discussion of diseases, diagnoses, treatments, and cost. Public discussion by local physicians could be an effective component of developing public confidence in the health care system. There is some expressed willingness to pay more for better health care, among those who can, and it is prudent public policy for a government to make improved services available to entice educated people not to leave the country.

In general, people are not satisfied about health care, but there is little public discussion of the issue. Comments made were: "Everything is stifled." "Many of us

have never seen a minister in public before." "Issues aren't discussed." "All looks good on paper." It is clear that health care financing is a sensitive political issue. However, it will not be resolved until there is open public policy dialogue. Politicians need to be convinced that this is a step that needs to be taken. Therefore, they must be sufficiently informed about options so that they can discuss them publicly without fearing for their political well-being.

Comparisons between private and public services within countries could be a basis for education about the need for additional resources and management of the health care sector. This could lead to plans for improving the allocation of resources. Government has the central role because of the extent to which it is the primary purchaser and provider of health care services. Before plans are put in place to raise fees for hospital or other care, education for public awareness must be provided.

**Developmental Assistance:** The development of educational programs about the costs of health care, the present sources of payment, the long-term costs of improvements, the role of citizens in controlling utilization of health care resources, the availability of long-term funding, etc., would be useful for citizens, bureaucrats and policy makers in all countries.

A policy and government workshop on health care financing could provide needed information to policy makers to expedite policy revision. Also, there is much work needed in public education and public relations to increase understanding and to elicit informed responses. Education in the community could include how to make suggestions to improve hospital services, how to express dissatisfaction with the hospital, or how to offer personal suggestions or volunteer services to the hospital. Methods could include involving the public in the health care system through public meetings, advisory boards, patient advocates, volunteer programs, suggestion systems, etc.

### **3. Development of Regional Data Modeling Capability**

Presently, there is no common data base for planning. The development of a diagnostic data base with information for health planning and utilization controls is needed. In Dominica, data capability is available in the project management office and in the economic development unit. In Grenada, the need is recognized for position descriptions, staffing ratios, work load measurement tools, cost finding for units of service, charges which reflect actual costs, and revenue which reflects actual charges. In general, there is recognition that the time to begin information-based management is arriving in the health care sector.

**Developmental Assistance:** There could be a model for health care financing data developed for the region that accumulates data for aggregation and comparisons. The data should be gathered according to a data dictionary so that the data can be

combined or separated as needed for different purposes. A data dictionary describes all the components of a data base. Pieces developed in different countries can be transferred to other countries to reduce development costs.

This type of data base has the added advantage of providing regional and country comparisons. Data abstracting procedures should include data on length of stay, births, deaths, admissions by diagnosis, and other data necessary for health care planning.

## **VI. POTENTIAL FOR PRIVATIZATION**

Privatization brings private incentives and management to public enterprises. It relieves the government of the burden of paying constantly for services needed only intermittently, and of the financial burden of having full-time employees in positions where casual labor can provide the services adequately. It shifts the burden of providing capital from the government to a management authority with a clear mandate to fund capital equipment and depreciation in a manner far more effective than some governments may have been able to achieve. When capital requirements present barriers to contracting, ownership of capital can remain in the government, with various arrangements made for gradual transfer of the capital to the contractor, or for retention by the government.

Privatization is understood differently in the various EC countries. Privatization in the health care sector is understood as contracting out hospital or public health services. The objective is to provide institutional services at a lower cost, with equal or better quality.

Some EC countries have used privatization successfully at both the public utility levels and at the hospital groundskeeping level. They have hired a contractor to take over the management of a department in what is a very informal privatization effort. For more complex hospital services, the divestiture process may involve the government at the policy level in addressing the issues of abolishing civil service jobs, making settlement with displaced employees, and establishing government responsibility, policies and procedures to manage the new contractor. Effective management of new contractors requires the establishment of standards of performance for contractors' employees and for overall contract objectives.

Various degrees of privatization, or assumption of risk by the non-governmental managers, may be undertaken. The rewards to the entrepreneur are usually commensurate with the risks taken. Assumption of full management responsibility and risk by the entrepreneur is therefore the most lucrative option. Alternatively, management may be provided with full financial risk remaining with the government. A hybrid situation would have a public/private partnership responsible

with the risks and benefits shared proportionate to the investment. The details of an experiment comparing these options is presently underway in Jamaica. A Health Facilities Trust has also been proposed which would have the government own, staff, and finance facilities which would be leased to a contractor who would contract with the government to manage them.

#### **A. MANAGEMENT OF HEALTH SERVICES**

In Dominica, the electricity service, DOMLEC, is run as a para-statal organization. The water and sewage service, DAWASCO, is in the process of being similarly divested. There also has been a successful implementation of privatization by hiring an outside groundskeeping service. A contract has been let for maintenance of the newly constructed outpatient services area. Perceived benefits are improved quality of service and reduced costs. Consideration is being given to contracting out laundry and food service.

In Grenada, the government has privatized telephone and printing. Television was made a public corporation. The government is considering divesting electrification. The government expects to use money received from the divestiture to finance capital projects.

There may be a climate of interest in privatization and divestiture in St. Kitts. The government has approached the Caribbean Development Bank to set up an electricity corporation, with the government as interim sole shareholder, and the prospect of later selling shares to the public. Other examples are the Frigate Bay Development Corporation and the Central Marketing Corporation.

In St. Lucia, interest was expressed in privatization, especially in the contracting of ancillary services such as buildings and grounds, maintenance, kitchen and laundry, and possibly of medical equipment and technology.

#### **B. SERVICE PROVISION AT PUBLIC SECTOR HEALTH FACILITIES**

The only example of the privatization of medical services cited in the EC countries was coverage for the emergency room in St. Kitts during the evenings and nights when the full-time staff was not available. In no other cases did the doctors running the ministries think that the government doctors providing medical care should be replaced by some other group of doctors working for some other agency.

### C. PAYMENT MECHANISMS FOR HEALTH CARE

In regard to using a third party as a financial intermediary for paying for health care, there was recognition of the commercial insurance sector assuming the responsibility from the government. At the same time, there was some fear that some deserving poor would be deprived of health care services because of the profit motive of the private sector. There was also the belief that the private sector was a better source for the management of national health insurance funds because they understood efficiency in a way that the public sector did not.

**Developmental Assistance:** Technical assistance could focus on exploring the opportunities for privatization in the health care sector. Privatization is a device to shift the burden of providing public services from the government to the private sector. It can provide local entrepreneurs with opportunities to develop businesses to provide services to the hospital or other Ministry of Health facilities. It can provide the hospital with reduced personnel costs and capital investment. Different departmental activities will lend themselves more to this option than others. Criteria for considering privatization should include:

- The availability of local entrepreneurs with sufficient skill and experience to assure their ability to provide the required service to the hospital;
- The risk to the hospital and to the government of dismantling existing capability;
- The form of the privatization, whether contract management or purchased services; and,
- The short- and long-term costs of obtaining services under the different options.

Training for entrepreneurs could be developed to facilitate privatization of some aspects of health care services where the market may not provide adequate experience. In addition, USAID could make available to secondary schools curriculum support for people entering into this field, health professionals and para-professionals, such as technicians and managers of small enterprises. Another mechanism that would assist the development of privatization is the availability of low-interest loans to firms seeking to enter this field. These loans could be provided or guaranteed by USAID. These activities help create entrepreneurs through training and developing competition.

## VII. CAPITAL AND RECURRENT HEALTH CARE EXPENDITURES

### A. ALLOCATIONS OF NATIONAL BUDGETS TO HEALTH ACTIVITIES

The following tables specify, by capital and recurrent expenditure, the percentage of national budgets devoted over the last three fiscal years to health care for three of the four EC countries visited.

Table 1 shows health capital expenditure as a percentage of national capital expenditure and Table 2 shows health recurrent expenditure as a percentage of national recurrent expenditure. Data were not available for the fourth country.

Regarding the 1991 capital budget for St. Kitts for health and total expenditures (Table 1), it can be observed that the 1991 figures, which are "estimated, approved and projected" are much higher than figures for previous years. The explanation given was that the estimated, approved and projected figures included expectations for foreign assistance which may or may not materialize.

In any single country of the three shown in the tables, large variations over time for capital and recurrent expenditures appear. While a comparison of recurrent expenditures (Table 2) shows percentages within a range of eight to fourteen percent, a comparison of capital expenditures (Table 2) reveals that the amounts of capital expenditure for health in dollar terms and as a percentage of national public expenditure are far greater in St. Lucia than in Dominica or St. Kitts. The figures for St. Lucia range from sixteen to twenty percent, whereas those for St. Kitts and Dominica range from one to four percent, except for Dominica in 1988/89.

It may be interesting in the future to investigate this difference between St. Lucia and the other islands. Is it, for example, a function of greater foreign assistance, or is it attributable to other factors? There appears to be no obvious relation between percentage invested and GNP per capita, which is US \$1,540 for St. Lucia (1988), US \$1,650 for Dominica (1988) and US \$2,770 for St. Kitts (1988). (Grenada is US \$1,370 [1988].)<sup>1</sup>

Despite relatively high capital investments, the population per physician of 3,831 in St. Lucia is higher than in Dominica, where it is 3,080, or St. Kitts, where it is 2,245. (Grenada's is 2,141.)<sup>2</sup>

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<sup>1</sup>World Bank, *Social Indicators of Development, 1989*.

<sup>2</sup>*Ibid.*

Table 1  
HEALTH CAPITAL EXPENDITURE  
as a percentage of  
NATIONAL CAPITAL EXPENDITURE (EC)

	1	2	3	4	5	6	7	8	9	10	11	12
	1991/1992			1990/1991			1989/1990			1988/1989		
	HEALTH	TOTAL	%	HEALTH	TOTAL	%	HEALTH	TOTAL	%	HEALTH	TOTAL	%
DOMINICA	3,468,260	81,362,410	4.26	588,649	56,862,320	1.04	824,142	63,304,197	1.30	6,157,234	48,064,076	12.81
ST. KITTS	1,450,000	85,094,769	1.70	80,210	12,181,913	0.66	457,422	31,154,121	1.49	1,070,094	42,829,290	2.50
ST. LUCIA				26,340,476	152,521,477	17.27	31,520,995	153,846,829	20.49	15,911,686	97,442,224	16.32

DOMINICA

Column 1 - 1991/1992 "estimated" p. 331 & p. 355

Column 2 - 1991/1992 "estimated" p. 331

Column 7 - 1989/1990 "actual" p. 355

Column 8 - 1989/1990 "actual" p. 356

Column 10 - 1988/1989 "actual" p. 355

Column 11 - 1988/1989 "actual" p. 356

SOURCE: 1991/1992 Estimates of the Commonwealth of Dominica

ST. KITTS

St. Kitts uses a Fiscal Year that is the same as its Calendar Year.

Column 1991/1992 shows Fiscal Year 1991 for St. Kitts.

Column 1990/1991 shows Fiscal Year 1990 for St. Kitts.

Column 1989/1990 shows Fiscal Year 1989 for St. Kitts.

Column 1988/1989 shows Fiscal Year 1988 for St. Kitts.

ST. KITTS (cont'd)

Columns 1 & 2 - 1991 "Estimated, Approved and Projected"

Columns 4 & 5 - 1990 "Actual"

Columns 7 & 8 - 1989 "Actual"

Columns 10 & 11 - 1988 "Actual"

SOURCE: St. Christopher and Nevis Estimates for the Year 1991.

Adopted by the National Assembly on December 3, 1990.

St. Christopher and Nevis Estimates for the Year 1990.

Adopted by the National Assembly on December 5, 1991.

1990 Audited National Accounts

ST. LUCIA

The numbers provided do not indicate whether they were estimated or actual.

At the time of Report Preparation (October 1991) the market exchange rate was US\$1.00 = EC\$2.6882.

Table 2  
HEALTH RECURRENT EXPENDITURE  
as a percentage of  
NATIONAL RECURRENT EXPENDITURE (EC)

	1	2	3	4	5	6	7	8	9	10	11	12
	1991/1992			1990/1991			1989/1990			1988/1989		
	HEALTH	TOTAL	%									
DOMINICA	19,870,250	144,842,210	13.72	17,513,119	135,352,990	12.94	15,274,227	111,236,666	13.73	14,502,226	103,383,808	14.03
ST. KITTS	11,193,367	98,849,068	11.32	8,361,636	105,748,246	7.90	9,254,171	85,438,946	10.83	7,400,020	78,008,589	9.49
ST. LUCIA				29,416,367	236,725,160	12.43	24,731,755	216,567,090	11.42	21,905,850	190,090,268	11.52

DOMINICA

Column 1 (1) - "Estimated" p. 281  
Column 4 (2) - "Revised Estimated" p. 281  
Column 7 (3) - "Actual" p. 281  
Column 10 (4) - "Actual" p. 281

Column 2 (5) - 1991/1992 "Estimated" p. 17  
Column 5 (6) - 1990/1991 "Revised Estimated" p. 17  
Column 8 (7) - 1989/1990 "Actual" p. 17  
Column 11 (8) - 1988/1989 "Actual" p. 17

SOURCE: 1991/1992 Estimates of the Commonwealth of Dominica

ST. KITTS

St. Kitts uses a Fiscal Year that is the same as its Calendar Year.

Column 1991/1992 shows Fiscal Year 1991 for St. Kitts.  
Column 1990/1991 shows Fiscal Year 1990 for St. Kitts.  
Column 1989/1990 shows Fiscal Year 1989 for St. Kitts.  
Column 1988/1989 shows Fiscal Year 1988 for St. Kitts.

ST. KITTS (cont'd)

Columns 1 & 2 (1) 1991 "Estimated, Approved and Projected"  
Columns 4 & 5 (2) 1990 "Actual"  
Columns 7 & 8 (3) 1989 "Actual"  
Columns 10 & 11 (4) 1988 "Actual"

SOURCES: St. Christopher and Nevis Estimates for the Year 1991.  
Adopted by the National Assembly on December 3, 1990.

St. Christopher and Nevis Estimates for the Year 1990.  
Adopted by the National Assembly on December 5, 1991.

1990 Audited National Accounts.

ST. LUCIA

The numbers provided do not indicate whether they were estimated or actual.

At the time of Report Preparation (October 1991) the market exchange rate was US\$1.00 = EC\$2.6882.

All countries claim universal access to health care. Their immunization rates for children under twelve months vary:

<b>COUNTRY</b>	<b>MEASLES</b>	<b>DPT</b>
Dominica	85	84
Grenada	31	76
St. Kitts	85	97
St. Lucia	60	83 <sup>3</sup>

It may be useful in the future to look at recurrent and capital expenditures on health care and compare them with basic health indicators, with a view to investigating in a very general manner the relationship between public expenditure and other indicators of investment in health care.

Although there may not be a relationship between expenditures on health care and indicators such as GNP per capita or population per physician, these indicators have been mentioned because readily available data for comparisons across these three countries appear to be limited. Implementation of a regional database, as recommended elsewhere in this report, may help to better reveal relationships.

## **B. OTHER FINANCIAL RESOURCE ALLOCATION TRENDS**

### **1. Care Purchased Outside the Country**

In all the EC countries, large expenditures are incurred by both government and individuals for services purchased outside the country. Analysis is needed to compare the cost of providing health care services for citizens outside the country, as compared to purchasing the capital equipment and staffing the service. Analysis of the cost of using regional referral services could inform capital investment decisions and individual referrals. The range of costs for the same service may be six times higher in neighboring countries than at home. There is also a price differential among the countries for the same service.

**Developmental Assistance:** Referral programs were designed to fund out-of-country medical care for those patients whose medical needs cannot be met in the country. Referral costs can be reduced by better management of hospital facilities, establishment of a reliable flow of medical supplies, purchasing of necessary yet inexpensive equipment, maintenance of existing equipment, and training of physicians and ancillary staff. In addition to high cost, referrals cause loss of hard currency and inability of local health care systems to fund services.

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<sup>3</sup>*Ibid.*

## **2. Physicians' Compensation**

The physicians interviewed were all concerned about the level of compensation for their services. There are physician recruitment problems in the EC. One pediatrician slot has been vacant for five years. Salaries are low by international standards and there are unclear expectations about the roles, obligations and responsibilities of physicians. There is some organizational conflict between private practice and public employment and doctors are forced to compete with themselves as their private patients may try to see them in public facilities so that they do not have to pay a fee.

Private practice is difficult to establish. In one country, the number of physicians has tripled (from 10 to 30) while the population has not increased. In fact, the last census is said to have shown a ten percent decrease in population. In another case, a country refused to allow a physician to leave who had been recruited for a post in another country. Such a social constraint is also a disincentive for those who might work in the Caribbean.

More understanding is needed of the role of private practice for consultants. Different physicians have different private practice privileges. Casualty and district doctors may be allowed private practice while other government doctors are prohibited from private practice.

**Developmental Assistance:** A full study of the physician supply and compensation available should be conducted. This study would support analysis of the cost of staffing and form part of a regional planning effort. The health care system will not prosper without an adequate supply of the physician staff required. It would also be useful to do an analysis of physicians' salaries in different countries and their impact on recruitment and migration. Finally, compensation plans should be revised to determine the extent to which physicians may remain government employees.

## **APPENDICES**

- A: SCOPE OF WORK**
- B: LISTS OF PERSONS INTERVIEWED**
- C: ITINERARY**
- D: COUNTRY VISIT SUMMARIES**
- E. INTERVIEW GUIDE**

**APPENDIX A**  
**SCOPE OF WORK**

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## II. SCOPE OF WORK

- A. The Contractor shall provide two (2) short term experts, a health economist and a health system manager, to conduct the following scope of work culminating in the preparation of reports to be used by USAID/RDO/C to develop a Project Identification Document (PID) and a Project Paper.
- B. The experts will meet with USAID officials upon execution of this contract and determine a work plan, including sharing of responsibilities for completion of the scope of work. Preparation of the report will be coordinated so that a single joint report, addressing all the requirements of the SOW, will result as a deliverable.
- C. Activities:
  1. Review the reports of previous studies done in the Eastern Caribbean concerning health care financing, and management systems in the health sector;
  2. Visit selected island countries of the Eastern Caribbean to meet with health sector officials, both public and private, and health insurance personnel;
  3. Interview regional and country-based health officials at PAHO, USAID, EEC, CIDA and any other donors of health financing international organizations;
  4. Analyze the management and structural improvement needs of the health sector of the target EC countries, with the aim of making the sector more efficient and responsive to satisfying the health needs of its citizens in an equitable way. This should include hospital management and operational systems, financing arrangements for public health and hospital care, and assessment of demand for health care at various levels.
  5. Assess institutional capabilities in EC countries to implement management improvements, and suggest interventions required to make health sectors ready to undertake structural changes;
  6. Assess the health policy framework in EC countries, the need for change to these in order to implement the required structural and management changes, the possibilities for and the facility with which these changes might be made, given current circumstances;

7. Assess the potential in the Eastern Caribbean for privatization of the management or of service provision at public sector health facilities;
8. Identify, and specify by capital and recurrent expenditure, the percentage of national budgets devoted over the last three fiscal years to health care;
9. Document these analyses, and make recommendations for USAID assistance, based and prioritized on USAID comparative advantage as against other donors'.

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**APPENDIX B**  
**LISTS OF PERSONS INTERVIEWED**

**APPENDIX B**  
**LISTS OF PERSONS INTERVIEWED**

DOMINICA

Dr. Dorian Shillingford	Chief Medical Officer, Ministry of Health, Dominica
Ms. Irma Edwards	Assistant Secretary, Ministry of Health, Dominica
Ms. Doreen Nicholas	Permanent Secretary, Ministry of Health, Dominica
Mrs. Frances A. Charles	Member of the Board Dominica Employers Federation
Ms. Jean Jacob	Principal Nursing Officer, Ministry of Health, Dominica
Mr. Jules Lawrence	Ministry of Finance, Dominica
Mr. Curtis R.T. Tonge	President, Tonge Insurance Consultants, Ltd., Dominica
Ms. Susan Nesty	Hospital Administrator, Dominica
Ms. Masala Powell	Hospital Accountant, Dominica
Mr. Eisenhower Douglas	Economic Development Unit, Dominica
Ms. Annie Warner	Senior Project Officer, Dominica
Mr. Austia	Senior Projects Officer, Dominica
Dr. Ricketts	Head of the Medical Society, Grenada
Ms. Masala	Project Management Staff, Dominica
Ms. Lewis	Project Management Staff, Dominica
Evadne Richards	Hospital Matron, Dominica
Mr. Sylvester	Accountant General, Dominica

GRENADA

Mr. Phillip Gittens	British American Insurance Co., Grenada
Mr. Kennedy F. Roberts	Economist/Health Planner, Grenada
Mrs. Cynthia Horsford	Permanent Secretary for Health, Grenada
Dr. E. P. Friday	Chief Medical Officer, Grenada
Mr. Douglas Andrews	Hospital Administrator, Grenada

Mr. Richard Duncan	Director, Budget and Planning Ministry of Finance, Grenada
Mr. Chester John	Manager, CLICO, Chairman, Board of Directors, National Insurance Scheme, Grenada
Mr. Leroy Robinson	Manager, National Insurance Scheme, Grenada
Dr. Roger Radix	Grenada Medical Association
Honorable Michael Andrew	Minister of Health, Housing and the Environment, Grenada

ST. KITTS

Dr. Ian Jacobs, MD	DMO, Pediatrician, Medical Association Representative, St. Kitts
Ms. Moving	National Caribbean Insurance, St. Kitts
Dr. Kathleen Allen-Ferdinand	General Practitioner, St. Kitts
Dr. Patrick A. Martin	Pediatrician, St. Kitts
Mr. Eugene A. Hamilton	General Manager, National Caribbean Insurance Company, Limited, St. Kitts
Dr. O'Loughlin	General Practitioner, St. Kitts
Mr. Calvin Edwards	Budget Director, Ministry of Finance, St. Kitts
Dr. L.C. Richardson	Hospital Medical Superintendent, St. Kitts
Dr. Clive E. R. Ottley	Obstetrician, St. Kitts
Ms. Joseph	Hospital Accountant, St. Kitts
Dr. L.C. Richardson	Hospital Medical Superintendent, St. Kitts

ST. LUCIA

Mr. Percival McDonald	Permanent Secretary, Ministry of Health, Castries, St. Lucia
Mr. John G. Husbands	Health Planner, St. Lucia
Dr. O. N. King	President of the Medical Society, St. Lucia
Mr. Llewellyn Gill	Accountant General, St. Lucia
Mr. Albert Cenac	Social Insurance Scheme, St. Lucia
Mr. Augustin Louis	Social Insurance Scheme, St. Lucia
Senator George Louis	St. Lucia
Mr. Francis Comptom	National Insurance Scheme, St. Lucia
Mr. Noel Cadasse	Managing Director, First National Insurance Co., Ltd., St. Lucia
Ms. Sephlin Lawrence	Social Security, St. Lucia

BARBADOS AND WASHINGTON, D.C.

Dr. Aubrey Armstrong	Former head of CARICAD, Barbados
Dr. Eduardo Carillo	PAHO Management Adviser, Barbados
Mr. Gerald Cashion	Project Development Officer, USAID/RDO/C, Barbados
Ms. Rebecca Cohn	Chief/HPE, USAID/RDO/C, Barbados
Ms. Molly Crawford	TvT Administrative Assistant, Barbados
Mr. Sam Dowding	Senior Health Advisor, USAID/RDO/C, Barbados

Mr. Halmond Dyer	PAHO Caribbean Programme Coordinator, Barbados
Ms. Vernita Fort	Economist, USAID/RDO/C, Barbados
Mr. Jack Galloway	URC, Washington, D.C.
Ms. Ana Rita Gonzalez	PAHO Hospital Administration Adviser, Barbados
Mr. Elson Harewood	Controller's Office, USAID/RDO/C, Barbados
Mr. Roger Hill	Technical Adviser, Delegation of the Commission of the European Communities, Barbados
Ms. Mosina Jordan	Director, USAID/RDO/C, Barbados
Ms. Lani Marquez	URC, Washington, D.C.
Mr. Winston McPhie	Project Development Office, USAID/RDO/C, Barbados
Mr. R. E. Schroeder	Economic Adviser, Delegation of the Commission of the European Communities, Barbados
Ms. Alice Yu	Controller's Office, USAID/RDO/C, Barbados

**APPENDIX C**  
**ITINERARY**

**APPENDIX C  
ITINERARY**

<u>PLACE</u>	<u>DATE</u>	<u>ACTIVITY</u>
Washington, D.C.	September 30 to October 2, 1991	TvT orientation and team organization and task assign- ments
Barbados	October 2-6, 1991	USAID and con- tractor interviews and review of reports
Grenada	October 6-9, 1991	Country interviews
St. Lucia	October 9-13, 1991	Country interviews
Dominica	October 13-16, 1991	Country interviews
St. Kitts	October 16-20, 1991	Country interviews
Barbados	October 20-28, 1991	Report writing, review, revision and submission
Washington, D.C.	November 11-15, 1991	Report revision

**APPENDIX D**  
**COUNTRY VISIT SUMMARIES**

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**APPENDIX D**  
**COUNTRY VISIT SUMMARIES**

**Preliminary Dominica Country Summary**  
**October 16, 1991**

ALL THE COMMENTS IN THIS DOCUMENT ARE THE RESULT OF INTERVIEWS WITH APPROXIMATELY A DOZEN PERSONS. THE FINDINGS ARE ANECDOTAL AND IMPRESSIONISTIC. A CONSCIENTIOUS EFFORT WAS MADE TO AVOID MISREPRESENTATION. OBSERVATIONS DO NOT NECESSARILY REFLECT GOVERNMENT POLICY OR DEFINITIVE PLANS.

- Health sector (Mcintyre) report which recommended raising fees was considered by the government and put on hold pending more information.
- The government system needs increased user fees. There is some feeling that the need to fund a certain percentage of the health system could be met by a social security or other tax increases. Analysis of the impact of the various options is necessary. Some persons feel that action needs to be taken in regard to fees first in order to stop the system from failing further. Additional analysis can follow.
- Private insurance is no longer being sold because of overutilization by subscribers and increasing charges by providers. Insurance changed the payment method to the beneficiary rather than the physician to slow fee increases.
- Group policies now provide coverage for overseas treatment. Preference is now for services available in Martinique even though the prices are very high. 3000 French francs per day is the cost of ICU. 2000 - 2500 per day is charged for routine hospital care.
- Political tradition is that government will provide care. It provides ambulatory care to the poor. The middle class use private physicians for ambulatory care. Both use the public system as much as possible to avoid high costs.
- Hospital fees are the same as when they were begun over five years ago. Health care financing actions that were expected from the legislature this past June or July are now postponed until next session. It was stated that fees cannot be raised without knowing what the other islands are doing because all countries are too close together.
- Some progress has been made at the hospital in the collection of fees.

- Public health system is extensive and functioning. Some staffing problems exist. Too much bypassing health centers to come to the hospital. Education program is needed.
- There is a good standardized staff development program for hospital nursing and public health nursing. Family nurse practitioner training is active.
- There is confusion about the role of the social insurance scheme in health care financing. There is feeling that their beneficiaries should be exempt from fees only to the extent that the transfer payment covers the cost of their care. Citizens and SS staff have an exaggerated understanding of how much health care SS covers. Education is needed for all parties. It should be part of an overall educational program to inform people about health care financing options and their responsibility to provide for their own care.
- Some discussion was held about the nature of ordinary medical care versus extraordinary medical care and the role of this distinction in describing government responsibilities and, possibly, the role of commercial insurance. These issues depend on definitions of entitlement and resources available.
- There is a lot of public discussion and interest in the health care system. There is political indecision about whether to make changes now or later, which reflect political considerations. There is awareness that costs at the hospital must be increased. But awareness that increasing charges will not help much because it squeezes the pensioner and the young and unemployed.
- There was discussion about the role of consultants and the nature of good technical assistance. Many of the nationals' expectations can be incorporated into the proposed project. Examples are: staff the project regionally; focus on training; consultants are to develop and transfer systems (they are not to be contract labor who leave only a vacant job behind them); all deliverables should be delivered via certified mail halfway through the technical assistance time period. This will leave time for training, debugging and further development by the clients. This process will assure effective skill transfer.
- Commercial insurance when first offered processed 300 claims per month. There was no deductible. Fees for medical office visits were paid with no limits. However, many subscribers still used their social security card instead of their commercial insurance. This was even done in cases of insurance physicals. Education of the public is needed, as soon as the government determines its policy goals and ability.
- Commercial insurance is sometimes considered unattractive because subscribers received the same level of care as those who did not pay.

- An opportunity exists to increase revenue from foreigners by having a set of non-resident fees. People now come for obstetric/gynecological care from Antigua, Montserrat, and elsewhere.
- Emergencies are sent to Martinique, Guadalupe, and Barbados. Orthopedics care, cancer care, and burn cases are also sent out.
- Hospital accounts are receiving some attention. Emergencies and discharges on weekends often escape payment because of staffing. There is recognition that people are not interested in paying because they have never had to pay. Furthermore, people do not know that they have to pay. They feel their payment is insignificant because what they receive is so great in relation to the fee.
- There is awareness that the demand for services reflects people's perceptions of quality of care. Improved services will bring about increased demands for care. The authorities do not want to disenfranchise the needy or over-encourage unnecessary utilization. To control this system, planning and long-term financing strategies must be formulated.
- There is a belief that there are too many deliveries at the hospital which could be done at health centers. Some policy analysis, education, and clinical and triage guidelines are needed.
- The belief that action, not analysis, is needed was resolved in discussion to the recognition that a policy and government workshop on health care financing could provide needed information to policy makers. This education process should be extended to the public.
- Also, there is much work needed in public education and public relations to increase understanding and to elicit informed and appropriate responses from people in regard to their health care needs.
- All this has to be done in circumstances where it is government policy in regard to health-care--that access is not discretionary.
- A suggestion was made that in some countries physicians receive a percentage of hospital billing for their assistance in collections.
- The dental fee per item is very low. It is a free service for children. People do not appreciate the service because it is free. People come from St. Thomas and St. Martins for low priced care. December fillings are booked now. Fees are in revision to charge non-residents full economic cost plus 10 percent. This is still too low.

- There are physician recruitment problems. A pediatrician slot has been vacant for five years. Salaries are low by international standards.

**Preliminary Grenada Country Summary**  
**October 9, 1991**

ALL THE COMMENTS IN THIS DOCUMENT ARE THE RESULT OF INTERVIEWS WITH APPROXIMATELY A DOZEN PERSONS. THE FINDINGS ARE ANECDOTAL AND IMPRESSIONISTIC. A CONSCIENTIOUS EFFORT WAS MADE TO AVOID MISREPRESENTATION. OBSERVATIONS DO NOT NECESSARILY REFLECT GOVERNMENT POLICY OR DEFINITIVE PLANS.

- User fees for hospital room revisions are now before the legislature.
- A revision of the system for paying for surgery at the hospital is also being considered. Medical staff representatives have agreed to this.
- Desirable features of the proposed fee change include a formal collection mechanism, a pre-specified allocation of fees; a possible set-aside from the consolidated fund so that fees are not lost to the health system, and a role for the DMO as gatekeeper.
- Renovations and the development of a hospital admissions suite will provide an opportunity to learn to control admissions and collections and to support the development of medical records.
- Development of hospital policies and procedures is a high priority.
- Staffing analysis and task analysis, necessary to understand (and control) costs, is a high priority.
- A minimal number of MOH staff are formally trained for their positions. Some courses in the highly technical aspects of their jobs would help with development of a sustainable health system.
- Implementation of a standard chart of accounts is a prerequisite for the development of an accounting system. It would be reasonable to recommend one for OECS consideration.
- A need exists to clarify the roles, obligations and responsibilities of physicians because of the difficulty in filling positions, absenteeism, and conflict between private practice and public employment.
- Analysis needs to be conducted of the cost of providing health care services for people who may not receive appropriate and timely interventions and who

therefore require more expensive treatment and experience more discomfort and risk from their illness.

- Demand studies need to be conducted to discover the number of people who need care but are too poor, disaffected, alienated, or uninformed to seek care; and, to discover attitudes about ability and willingness to pay.
- A study of the impact of commercial insurance on people's behavior and vice versa could result in improved utilization and parallel improved benefits.
- An issue of equity exists in the ability of physicians to push private patients to the head of the queue in a government hospital. The ethics of this in a particular country depend on the political philosophy of the government.
- The diffusion of medical technology is largely restrained by limited capital. Analysis of demand will reveal the economic and medical utility of equipment. Funding would dictate the efficacy of the equipment.
- Technical assistance in the process of health planning would enable local policy makers to have a structure within which to set priorities, and the ability to rationalize necessary decisions, such as program decisions in regard to resource allocation between primary and secondary care and capital budget decisions.
- Technical assistance at a broad level in how budgets are made, or some other training in intelligent decisions to try to de-politicize the budgetary process, could partially relieve people of the feeling that they are not in control. It might also increase their frustration at not being able to provide uniform care rationally.

**Preliminary St. Kitts Country Summary**  
**October 20, 1991**

ALL THE COMMENTS IN THIS DOCUMENT ARE THE RESULT OF INTERVIEWS WITH APPROXIMATELY A DOZEN PERSONS. THE FINDINGS ARE ANECDOTAL AND IMPRESSIONISTIC. A CONSCIENTIOUS EFFORT WAS MADE TO AVOID MISREPRESENTATION. OBSERVATIONS DO NOT NECESSARILY REFLECT GOVERNMENT POLICY OR DEFINITIVE PLANS.

- Fees at hospitals have not been raised for years. Yet demands for service increase drastically. Fees need to be brought in line with actual costs in order to maintain or improve the level of services. People pay next to nothing. One or two EC per day. The receipt costs more than the revenue.
- A committee of ministers was asked to review fees during August 1991. There is no evidence that the committee has met yet.
- Capital expenditures are generally funded from surplus funds. There has been no sizable surplus for some time. Therefore, there only have been limited capital expenditures.
- Budget committees in each ministry make estimates based on previous expenditures. If a department did not spend its funds the previous year, the estimate is reduced. There are several bureaucratic impediments to orderly spending.
- Assistance is needed to:
  - rationalize the basic health care plan,
  - set politically acceptable and hopefully realistic fees,
  - learn actual costs,
  - develop hospital management systems, and
  - develop billing and collection systems.
- Improvements are needed in resource planning and allocation to reduce the frequency of shortages at the hospital and to assure the presence of staff specialists when needed.
- There is limited space in the hospital. Therefore, stays tend to be relatively short. This is a positive situation that may change if a new hospital that is too large is built. The new hospital may increase space available from 164 to 250 beds. An American hospital axiom applies: "A built bed is a filled bed." If the country is having difficulty sustaining a low-technology hospital of 164 beds, a medium-technology hospital of 250 beds might be impossible to operate. It

is unlikely that a new hospital would attract enough paying patients from inside or outside the country to offset the increased operating costs.

- Ten percent of the labor force is now covered by commercial insurance. The anticipated addition of government employees under the new plan will about triple this number.
- The bank which holds the insurance company is a concern in which the government has 51 percent of the shares. The insurance company is part of a trust which is one of the holdings of the bank.
- Management systems and fee structures are now scheduled to be looked at by PAHO.
- The system now operates in a condition of precarious homeostasis. A balance is maintained between near shortage of supplies and funding periodic allotments.
- There are several bureaucratic disincentives to effective hospital management. All are functioning government cost optimizing strategies.
- Ad hoc approvals and spending constraints means restricted cash flow, irregular supplies, occasional shortages and outages, and overall reduced cost.
- Non-Kittitians pay double the room and board fees. Other fee differences also are billed.
- The physical plant was built in 1967 and is now technologically, though not necessarily functionally, obsolete. Hurricane damage was severe. The hospital is expected to be partially replaced by LOME 4 and 5 during the next several years.
- Primary immediate priority is to refurbish the physical plant. Painting is under way.
- No nurses have been trained for three years. School is to reopen this year.
- People recognize that the fees are anachronistic. The political option of turning people needing care into mendicants is not politically acceptable.
- The government plans to acquire an ultrasound. No cost study has been done to determine the frequency of use, the cost per exam, or if this is the best use of (hospital) capital.

- Private practice is difficult because the number of doctors has tripled, from ten to thirty, while the population has not increased. In fact, the last census is said to have shown a ten percent decrease in population.
- Hospital administrative policies and procedures are in need of a current review.
- Many necessary hospital recommendations are shelved because of lack of funds.
- Training is needed in management systems in order to enable the hospital staff to make the best of available resources.
- A suggestion was made that each island should specialize in some medical service. St. Kitts was suggested as a good site to develop a neonatology center. Cooperation is believed to be possible among Montserrat, Antigua, St. Kitts, and Nevis.
- Much equipment is the same age as the hospital and therefore declared obsolete by the manufacturer. It is difficult or impossible to repair due to the unavailability of parts.
- Overall systems analysis of equipment will be done by PAHO to help to determine equipment needs. Some LOME funding will be used for equipment.
- The Permanent Secretary would like to consider using ECDS for supplies to save funds. But they will require one-third of annual expenditures for deposit as they do for drugs. This is a lot of money to have tied up at no interest. Analysis here may reveal that the savings will offset the cost of lost interest. It may also show that increasing the reliability of the supplies will increase utilization and increase overall cost.
- The system is largely private-sector managed with most care provided by private practitioners except for patients who are children, elderly and retired.
- The administration is aware that there is discussion throughout the Caribbean countries about opportunities to make changes in social security to provide health care services.
- The SSA Director and Minister of Health have been to meetings in Antigua to discuss medical care financing. The director feels that the SSA should not be involved in health care.

- The SSA makes no annual contribution to the health care system. Rather, the SSA will buy specific items as requested. National grants mostly are made to hospitals on their request; there is not an annual round number.

**Preliminary St. Lucia Country Summary**  
**October 13, 1991**

ALL THE COMMENTS IN THIS DOCUMENT ARE THE RESULT OF INTERVIEWS WITH APPROXIMATELY A DOZEN PERSONS. THE FINDINGS ARE ANECDOTAL AND IMPRESSIONISTIC. A CONSCIENTIOUS EFFORT WAS MADE TO AVOID MISREPRESENTATION. OBSERVATIONS DO NOT NECESSARILY REFLECT GOVERNMENT POLICY OR DEFINITIVE PLANS.

- There is a growing awareness of the building blocks for a health care financing scheme in St. Lucia. Conceptually, the Permanent Secretary is willing to embrace the following aspects of a self-sustaining program.
- Financing options are recognized to focus on NIS. It could be incorporated partially with private insurance. It is related to the role of farmers' unions in light of their tax-free status.
- A study to determine the percentage of persons who can afford to purchase health insurance or who can afford commercial insurance would help policy formulation.
- Establishing an identification process requiring a card from NIS or farmers' association or another source is planned. People who are not members of associations and who do not have access to an organization will fall in another category of government responsibility for which a mechanism is still to be selected.
- The above steps are a model of an incremental approach. It has the merit that it will secure access to health care services for a certain segment of the population. It will also secure some additional revenue for the hospital.
- However, the mechanism by which the same services will be provided for the indigent and the medically indigent is still under development. The problem has been addressed in other countries. Decisions will reflect consideration of respect for individual privacy, and protection of government health care system resources.
- An area requiring some analysis is the funding and claims experience for commercial insurance companies. Wide fluctuations among group utilization indicates that individuals hold widely disparate views about what access to care purchasing an insurance policy should assure them.

- A possibility exists for the government to enter into a contract with commercial insurance companies to have them be the intermediaries in a government-mandated insurance program. Their fee for management and an agreed-upon profit can be negotiated. Incentives could be offered to the intermediary for effective management and control of utilization.
- More understanding is needed of the role of private practice for consultants. Different physicians have different private practice privileges. Casualty and district doctors are allowed private practice. Other government doctors are prohibited from private practice.
- Fire, police, and nurses are entitled to NIS benefits. Everyone else who is working, including other government employees, is not covered. Ninety percent of civil servants are not eligible. They must go to private insurance to obtain comparable coverage. Analysis is needed of the management ability and actuarial basis for the NIS to administer a national health insurance scheme.
- The view was expressed that the population cannot support a fully-equipped hospital. If facilities are not to be available in the country, the costs of obtaining services outside the country becomes very important. The issue of entitlement, long promised by many Caribbean governments, is at issue.
- The public expectations from the health care system are increasing as a result of television, especially the cable health channel. The demand is increasing for upscale health services for acute and chronic diseases. There are also increasing expectations for privacy and confidentiality. This is a challenge to the government because it cannot afford these services. And, politically, it cannot afford to ignore increasing expectations for services. The time may be approaching when pressures on the health care system may make it more politically realistic to educate people that they will have to pay for health services. This is a change from the myth that care can be provided by the government for free. Policy analysis and discussion with politicians is necessary to explore options.
- Development assistance is falling behind. Massive capital injections have overstated the government's view of self-sufficiency. The experience of paying for overseas care is instructive. It should lead to the examination of the regional planning of services to reduce long-term financial demands on the health care system.
- Planning overseas purchases for the hospital is in the process of being brought under control by the hospital administrator.

- In regard to the development of national health insurance, the likely role for the government is that of referee. What it would need to know to put legislation in place has not been learned for countries the size of these in the Caribbean. What is clear is that it is imprudent to recommend a massive government contribution. It represents an extreme burden that could only be considered with intense utilization control.
- The small state economies are getting past the stage of ad hoc health care financing. At the same time, private employers are becoming more shrewd. They will not volunteer to play an inordinate role in a national health care system. Work needs to be done in developing ways for the government to monitor the contributions of employers and employees. The government may have to set minimum standards to protect itself, the public, and the sick. At the same time, the role for the private sector must prevent fueling more health care costs.
- The role of intergovernmental cooperation is in development. A model agreement could be developed. The association of opposition parties is active in considering health issues.

**APPENDIX E  
INTERVIEW GUIDE**

FINANCING ARRANGEMENTS FOR PAYMENT FOR HOSPITAL CARE

Is there a hospital fee schedule?

When was it originally formulated?

How often is it revised?

What have the rates of increase been?

How are the fees paid?

- Free
- Government-paid
- Private insurance
- Self-pay

Amount of Revenue Collected

- Collection efforts
- Specify payment
- Other revenue
- Other revenue

DRUG PROGRAM

Participation

Satisfaction

Least liked item

- Another
- Another
- Another
- Another

Most liked item

- Another
- Another
- Another

**ASSESSMENT OF INSTITUTIONAL CAPABILITY TO IMPLEMENT  
MANAGEMENT IMPROVEMENTS HEALTH DEPARTMENT**

What is the most important agency in the health care system?

What are the three most significant advances in the recent history of the health department?

What is the most important agency outside the health care system?

What other outside agency is important to the health care system?

What other outside agency is important to the health care system?

Does the health department have a policy and procedure manual?

How often is it revised?

Does the health department have a long-range or development plan?

Are health department expenditures budgeted?

Do you have systems for monitoring the quality of care given in health department facilities?

Do you record employee absenteeism or turnover rates? Why?

What are the major management problems that you see in the next five years?

Are all patients cared for with compassion and dignity?

What are the three greatest needs in the development of health services in the future?

**ASSESSMENT OF INSTITUTIONAL CAPABILITY TO IMPLEMENT  
MANAGEMENT IMPROVEMENTS IN HOSPITALS**

What are the three most significant advances in the recent history of the hospital?

What outside agency is most important to the hospital?

What other outside agency is important to the hospital?

What other outside agency is important to the hospital?

Does the hospital have a policy and procedures manual?

How often is it revised?

Does the hospital have a long-range or development plan?

Are hospital expenditures budgeted?

Do you have systems for monitoring the quality of care given in the hospital?

Do you record employee absenteeism or turnover rates? Why?

What are the major management problems that you see in the next five years?

Are all patients cared for with compassion and dignity?

What are the three greatest needs in the development of hospital in the future?

**ARE INTERVENTIONS NECESSARY TO PREPARE FOR  
STRUCTURAL CHANGES?**

Do managers anticipate and plan for changing situations or do they merely cope with changes as they occur?

What efforts are made to develop the skills of managers in the hospital?

How is the performance of persons in managerial positions evaluated?

Do you use a system for goal-setting in the hospital?

Do you have a written statement of the mission, goals and/or objectives of the hospital?

Do you forecast staffing or financial needs?

Do you conduct assessment of managers' skills and plan for their development?

Do you have a management methods improvement program?

Are there adequate numbers of trained administrators to meet the future needs of the hospital?

**ASSESSMENT OF THE HEALTH POLICY FRAMEWORK TOLERANCE  
FOR CHANGE IN ORDER TO IMPLEMENT MANAGEMENT  
IMPROVEMENTS AND STRUCTURAL CHANGES**

What is the attitude of the citizens to the health care services they get in their country?

How do you know what these attitudes are?

What are the major health problems in your country?

Are the problems getting more serious or less serious?

What actions are planned to address these problems?

What health problems are you anticipating to develop in the future?

What actions are planned to address these problems?

Has the balance of funding between preventive and curative services changed in recent years?

Has there been a change in the allocation of funds between comprehensive and selective care?

Has there been a change in the allocation of funds between vertical and integrated health care programs?

Has any initiative been started or planned in the area of injuries?

Has any initiative been started or planned in the area of occupational disease and/or disability?

Has any initiative been started or planned in the area of preventable chronic diseases?

Has any initiative been started or planned in the area of adolescent pregnancy?

Has any initiative been started or planned in the area of identifying the major disease problems? Their social and economic consequences? The costs and effectiveness of different interventions? Has effort been made to define what range of policy instruments are available to the government?

In the area of education?

- In the area of persuasion?
- In the area of taxation?
- In the area of regulation of providers?
- In the area of regulation of access to services?

### **ASSESSMENT OF THE POTENTIAL FOR PRIVATIZATION**

Are there presently private components of your health care system?

What is the most important one?

What is its contribution to your system?

Does the government also provide the same service?

Are there differences in cost for the same service from both sources?

Would further development of these services reduce the cost of health services to the government?

How would the care of persons who could not afford privately operated care be met?

What arrangements exist for public/private cooperation in the provision of services?

What other arrangements might work?