Sparking the Debate:

The Introduction of National Health Insurance in the Bahamas

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“Can I sleep well at night secure in the knowledge that if anything happens to me or a member of my family, good health services will be accessible and affordable, that is, obtainable without risk of a severe and long-term impact on my financial well-being?”
Forward

The Government has declared to the Bahamian electorate that it will implement the National Health Insurance scheme for January 2016. They claim its now long overdue; enabling legislation was passed in 2007 and the national drug plan was launched in 2010. There is much activity already on the ground for the start date of this major health care reform. The “Consultants” have been summoned and recommendations have been submitted to the Cabinet. Stakeholders are being engaged. Committees have been formed; members appointed and meetings are ongoing. The Government means business. As a senior member of the medical community, I have been invited to participate and I would like to believe, actively involved in this process. It's a difficult undertaking, a major task. I hope we do it better this time and propose a plan we can all buy into.

The cost of health care in the country is high and many can’t afford to pay for private care. The mantra of the political platform is that no one can be denied care in government institutions because of inability to pay. So the people are flocking there and the hospitals are bursting at the seams. Suffice it to say, the care available is limited and the wait times are too long. Those who need care can’t get it as needed, when needed and those who need more, can’t get more.

In this major undertaking of reforming the health care system to the health care needs of the populace, the greatest stakeholder is the public. My concern is and always has been, that while there are those feverishly working to get it right, the public has not yet been engaged to have their voices heard.

Considering the clamour on the gambling referendum and the gender constitutional issues, I anticipate that the screams and the sparks would fly, as citizens from the newborn to the retirees, need and want to have their say.

So my Bahamian public- yes, it’s time to start the debate. I seek to jump-start the process and propose a framework for discussion on this complex issue of health care. This requires that we have an appreciation of the issues involved and this essay will hopefully do that.
Overview:

Accessing health care services in the Bahamas and being able to pay for it is untenable for both citizens and the government. The reality is that health care is too expensive: *Those who need care can’t get the care they need, and those who need more, can’t get it. People are hoping and praying for health care services and too many die waiting.* The need to reform the health care system to one that is affordable and sustainable and meets the health care needs of the citizens and residents of the Bahamas, is now a national crisis and demands urgent attention and implementation.

So how do we design a health care system? One that is meets the goal to provide affordable and appropriate quality (effective and efficient) health care with equal access to all citizens? We must recognize that health care systems are complex and many countries have introduced and implemented national programs to address this global and regional challenge. The following themes are identified and common to all national health submissions:

1. The recognition of health care as a right for all and that health care is a common good: All must benefit, all must contribute;

2. There is adequate financing and the acceptable means to collect the funds. Of equal importance, those who spend must account for its use and the outcomes, in order to justify the amount needed to collect;

3. There is no one correct way to frame and finance the system: the system reflects the culture, spirit, values and available resources of its citizens. In simple language: there is more than one-way to skin a cat and no one hat fits all;

4. There must be an acknowledgment of the new paradigm of consumerism in modern medical care in order for the health system’s financial sustainability. In concert with the introduction of consumerism in the delivery of health care services, the new dictum in health care must be value: *getting more for less* and designing a health care framework that is adaptable and adjustable to the new market forces and concepts in the health
The fact that up to 30 cents of each medical dollar spent accounts for wastage in the system, (Institute of Medicine 2014), must be a primary driver in this pursuit for financial sustainability.

5. The recognition of the new epidemic of life style diseases, the noncommunicable chronic diseases, must be a primary driver as well, with new models of care using the preventive and community-based approach;

6. To make this national cause a reality, there must be the political will to do it, with a commitment to accountability, transparency and consensus with the input of all stakeholders, if there is to be any semblance of a successful health care system.

This three-part essay seeks to define the complexities of designing a national health care system for the citizens and residents of the Bahamas and provides a framework for discussion:

- Part 1, **Setting the Stage - Framing the National Debate for Funding Health Care**, sets out to define the numerous and complex issues that need to be discussed in preparation for this national undertaking. It addresses the why, who, when, what and how of the system.

- Part 2, **Designing a National Health Care Funding Initiative for Bahamians** focuses on the Bahamian perspective, what makes us so unique? – What does culture have to do with it?

- Part 3, **The Buyers & the Sellers: the Economics of Providing Health Care for Developing Countries**, tackles the rising costs of health care amidst the commercialisation of the health care industry.

I hope you enjoy the read, and be more enlightened and motivated to join and contribute to this national debate.
Part 1:

Setting the Stage:
Framing the National Debate for Funding Health Care

We must be of 'like minds'
1. The High Costs of Health Care (HC) Services

The Government of the Bahamas spends a lot of money on providing HC; it’s an essential service, a must for everyone. This spending applies for all, the young and the old and those in between. For both the sick and the healthy, the Government spends 15 cents of every dollar earned to provide HC services for all Bahamians when they need it.

But, this is not enough.

• For non-emergencies, it could take months to get an appointment to see the doctor in the Government services. The booking times for clinic appointments are too long; in some clinics it’s a three to six month wait.

• The waiting times in the clinics to see the doctor are too long; some patients come from 7:00 a.m. just to ensure that they see the doctor for the 1:00 p.m. clinic. Some may still be turned away because of clinic overbookings; even 7:00 a.m. may not be early enough.

• Emergency visits fare no better, on death’s door - all day and all night, people seek and await medical attention for hours. Some will tell you they wait in excess of 24 hours for care in the Accident and Emergency Department at the Princess Margaret Hospital.

• People can’t be admitted into hospitals, all the wards are overcrowded – all the beds are occupied; patients are on stretchers filling the aisles wherever there are extra spaces. In some wards, patient bed occupancy exceeds 100% almost every day of the year.

• Surgery wait times could be six months or more; and then on the day of admission, the patient can’t be admitted because there are no beds available in the hospital. It’s a several month wait.

• People get sicker waiting, some die in the process.
We need more clinics, a bigger Emergency Department, more surgical operating rooms, more hospital beds, more doctors, and nurses. Yes, the Government needs more money to provide more efficient and effective health care services.

Then there are those services that we don’t have in the public sector, that patients must seek outside the realm of the government-owned facilities, such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET) scan, nuclear medicine, open heart surgery and radiation services. We need capital funds for these new major developments. Advances in medicine are dynamic, new discoveries occur every day, all promising us better and longer lives. But funds for capital development for expanding health and creating new services are very limited; the budget pessimists claim there is no more money available. There is no question about it; we need more funds desperately if we are to keep pace with modern medical advances and bettering the lives of Bahamians.

The critics protest; the issue is not increasing our resource capacity. Too much is spent on sickness. We should be focused on prevention: “An ounce of prevention is worth a pound of cure.” Advancing health education, health promotion and wellness programs, inculcating healthy lifestyles would result in tremendous savings in health care spending.

But we need money for prevention too. The expense of staying healthy can be just as high as the expense of sickness. A healthy diet of fruits, vegetables, low fat and low carbohydrate foods does not come cheap. Membership for gyms and tennis clubs also comes with a price. A national health promotion and education program is a costly undertaking. Suffice it to say, there is a need for much more money. Government needs more money to provide improved and expanded health care services; what we have is not enough.

The Bahamas is not alone. The high cost of providing adequate health care services is a global challenge. In the Organization of Economic Cooperation and Development (OECD) countries, the governments spend on average about $3500 per person annually; the USA spends twice as much, approximating $7000 per capita. By comparison, the Bahamas government spends an estimated $2000 per person per annum. The Bahamas still has a long way to go in health care spending – there is a lot of spending yet to do. The money, however, is just not there. The
pertinent questions to ask: Are we getting our money’s worth? Are we getting value for what we do spend? This is discussed later in the essay. The evidence suggests we certainly are not.

2. Paying for Health Care

So how do other countries do it, pay for health care for their residents? Do we have to reinvent the wheel? We certainly get a better appreciation of how to do this if we take a glance at providing for health care from the historical perspective.

After industrialisation in the 19th century and even more so after World II, welfare programs emerged and became a staple of national development. Health care became a societal good. The debate of health care as a right of all citizens or not, in today’s world, is a mute one. There is a collective persuasion that health care delivery should meet the criteria of the six “A’s”:

- Accessibility: the right or opportunity to receive health services
- Availability: all resources required would be supplied
- Affordability: can be readily purchased individually and/or collectively
- Appropriateness: the right care for the right problem
- All the people, Universal – provided for all citizens and residents
- Accountable: the money spent and care delivered should meet desired and planned outcomes

This collective responsibility is quite a challenge but it was not insurmountable. The options reflect three basic principles: Where will the money come from, how will it be collected, how will it be paid out and what should we be paying for?

**Paying the Medical Bills:** Who is going to pay for the health care services being delivered - The government, the individual or will it be a third party payer – a private insurance company or a government corporation? Could it be a combination of these sources?
Collecting the Funds to Pay for the Medical Bills: How will the money be collected to pay for the care and who will collect it? – Will it be done via general taxation or via dedicated health insurance funds deducted directly from wages? Can patients pay directly out of pocket as medical care is needed?

The Method of Paying the Health Care Providers: How are providers to be paid - Will it be via a single payer system or via dedicated insurance entities? Will it be paid as the service is being provided - fee for service? Or will the providers be prepaid and then held accountable for the service delivered? Could they be full time government employees versus independent service providers contracted individually or collectively? Or can services be outsourced and paid for collectively?

Paying for Which Services: It has become quite evident as medicine advances, the options for diagnosing and treating illness have become a compendium of choices. The physicians outline the shopping lists and the patient selects: which X-rays or laboratory tests? Should it be the minimally invasive or the traditional open type, or should it be surgery at all? There is a blurred line between what is needed versus what is wanted. The former is referred to as essential services and defining this list is a national debate. In the USA, the Oregon state health care plan was predicated on the list of diseases the population voted to be essential, and thus the government would pay the providers to take care of these diseases.

The funding elements noted above, highlight two other issues for debate in paying for health care as a national directive: Who should own the health care services? Should health care be solely a government owned entity or should it be solely privately owned? If private owned, should the owners be for-profit or non-for profit entrepreneurs?

Who owns and who pays are intimately involved; “who pays the piper plays the tunes.”

As a collective good, what should be the fundamental role of Government in the provision of health care? At one end of the spectrum, there are those who contend that government’s role should be as a regulator only and health care delivery should be privately owned, administered and funded. Governments do not have a stellar record in running things. At the other end,
there is the philosophy that by the very nature of being a fundamental right of all people with equal access and availability when in need of health care, it should be solely owned and administered by the government and funded from the public purse. In between the diametric poles are the various combinations of who and how to fund, collect and pay, and who should deliver and who is accountable and for what.

The truth be known, paying for health care reflects the values of a people. It sits within the revered halls of our belief systems like religion. Who should dictate and be responsible for our healthy lifestyle choices? When, what and how much to eat? When, if and how to exercise? If, when, where and who should determine our/choices to access health care providers? Health as a collective responsibility for individual rights and choices – no other public issue could be more controversial than this essential human need.

The first national effort to address and conclude the health care issue as a public need in a collective effort to provide equal access and availability for all and to be implemented was introduced in Germany in 1883. Britain did so 65 years later in 1948, Canada in 1973. The USA had a vicious national debate as the Accountable Care Act was introduced in 2013; the efforts to undermine and overturn it had to be settled by the Supreme Court; legislators are still seeking to have it overturned.

So Bahamas, what do we want? Who should pay for our health care? How should we collect the money? What should we be paying for and to whom? The government introduced a national health insurance scheme in 1988 and 2008. Have we really had a debate as to what is best for Bahamians? Have we really had a say and input, or has government in its usual way as the representative of the people, decided what is best for us? Is this what Bahamians want? If not, we must act fast – the government has set a target for its IMPLEMENTATION: JANUARY 2016.

But before we tackle this issue of the national design of a health care system for the Bahamas, it is imperative that we address first the issue of the high costs of health care. Health care is expensive and good health care is damn expensive. The constant mathematical factor to the health care design equation is its costs, how much we have to spend and what we can afford.
There is only so much we can spend; there are other essential services like education, transportation and housing that we have to pay for too. “If wishes were horses, beggars would ride.”

3. The Unbridled Costs of Health Care

At the time of introduction of the above national health insurance schemes in the 19th and 20th centuries, the cost of medical services could be defined and contained.

There were the fixed costs, attributed to our investments in

- technology and pharmaceuticals, the two major drivers of the costs of health care services and;

- education in our human resource development in health: doctors, nurses, allied health practitioners, health managers and administrators. Health care providers make huge financial investments and commitments in their education; reimbursing their services is costly.

There were the variable costs:

- The frequency and amount of services needed to diagnose and treat diseases, the so-called utilization of services. This is particularly noticeable in our elderly population – the reality is that as we age, we incur more diseases.

Nowhere was this more noted than at the time of the original Beveridge Manifesto for introducing the National Health Services (NHS) in Great Britain in the 1940’s. Sir William Beveridge believed that the NHS would defeat one of five “Giant Evils”. As better health services became readily accessed and available for all with no fees to pay, more people would be healthy; the disease burden and the costs of care would decrease. Within two years of introducing the NHS, the plan was heading for bankruptcy and fees had to be introduced.
The high cost of health care per se, however, is only a small part of the funding issue. It’s how fast it’s increasing. Medical care cost is increasing at an exponential rate, higher than the rate of inflation, and it’s doing so at the expense of other goods and services in the country.

This high and increasing, unbridled cost of health care services has become the central issue in health care, in every country and in every jurisdiction. It’s a political hot bed, representing the key issue on every political agenda. A plausible solution to funding health care defines a political platform and the politicians’ career; take note of President Barack Obama, President Bill Clinton or Prime Minister Tony Blair.

With the introduction of these national health funded schemes in recognition of this public good and hence, so should be funded, the current health care issues of high and mounting health costs were not as problematic then as it is currently. For those were the times when choices were few and the “doctor knew best”.

Medicine has changed - every facet of it! It happened in our lifetimes, right in front our faces.

• Medical education has changed, both in content and process, there is so much more to know. There are specialists, subspecialists and super specialists;

• The practice of medicine has changed: doctors no longer know best and are held accountable for every action; malpractice is rampant, 2 out of every three doctors in the USA have been sued at least once. In a 2011 New England Journal of Medicine study, 75 percent of physicians practicing in a low-risk specialty will have been sued by the age of 65 years, 19 percent will have made an indemnity payment. For those in the high risk specialties, 99 percent will have been sued by age 65, and 71 percent will have lost.

• The patients have changed: they are more knowledgeable and seek to direct their care. Doctors no longer dictate but inform and patients choose their options.

• A new perspective of medicine has emerged: it is consumer and industry driven and the laws of supply and demand economics and monopolies have inculcated the everyday language managing health services. The facts are that medicine has become
commercialised. In the USA, the burden of change has proven too much for some doctors; feeling a lost of control of the profession and their practice, many have sold their practices, some have quit.

In developing countries, many have yet to acknowledge that these changes have occurred; access and availability of health care still eludes them. They pay an additional price - the medical care providers - their nurses, doctors and allied health professionals are migrating to the developed countries for better working conditions and quality of life. Brain drain is a reality. In a 2009 study, *Brain Drain and Caribbean-EU Labour Mobility* from the Shridath Ramphal Centre for International Trade Law, Policy and Services in Barbados, the Caribbean region is reported to have some of the highest brain drain levels in the world. On a regional scale, on average more than 65% of CARICOM nationals with tertiary education migrated to the OECD countries between 1990 and 2000; some countries having emigration rates reaching over 70%.

In the final analysis, we must believe that everyone desires a health care system that seeks to deliver quality health care services with continuing better outcomes and one that is financially sustainable.

**Designing a National Health Care Initiative for Bahamians:** So back to reality, *Quo vadis?* Whither goest thou, Bahamas, in this quagmire of how best to fund health care in our global mandate to seek quality care for all our residents? First we must recognize our values and the idiosyncrasies of Bahamianism.

Despite our societal ills and dysfunction, we remain a country deeply rooted in Christian principles of daily living; we are our brothers’ keepers. We believe fundamentally that health care is a right of all people and as a societal right, the government has a fundamental role to play in the delivery of health services or to ensure that individuals are guaranteed that right. In our Christian values of doing unto others as we would ourselves, we believe that the right and availability of health care services for all must be underlined by the principle of health care equity: those who need care, receive the care they need and those who need more, can get more. These values and beliefs are noble and exemplary; but they carry a heavy cost.
The second dose of reality is our deeply engrained American values that we have inherited by the very nature of being on the doorstep of the world’s largest marketplace, and with unfettered access to travel to the United States of America. We are indoctrinated. Like them, we have become consumers of every possible commodity. We have accepted and embraced the concept that health care products and services have evolved into an industry with a multiplicity of products and production lines and with all the trappings of marketing and branding.

It is within this new dynamics of health care funding, where patients have become the purchasers of health care and the providers the sellers, financing health care takes on a new perspective.

At the turn of the new millennium, an appreciation and application of health care economics and its determinants, have emerged as the linchpin to advancing any health care delivery system or reform that seeks to deliver quality health care services with continuing better outcomes and that is financially sustainable.

It is within this context, Part 2 sets out to review the lessons learnt and the issues for consideration in providing health care for developing countries: Designing a National Health Care Initiative for Bahamians.
Part 2:

Designing a National Health Care Initiative for Bahamians

To the beat of our own drums
Part 1 of framing the debate to design a NHI or universal health coverage sought to ask the why, what, when, who, where and how this pertinent health issue should be addressed. The arguments are complex, protracted and stir emotions. The resolve, if any, reflects national and personal values, the political ethos, the economic realities and most importantly, the culture of its people.

At the onset, there is a need to clarify the relevant and related health care terminologies typically used interchangeably: national health, national health insurance, and universal health coverage. A national health system or plan is where the government mandates comprehensive and essential health care services to which all residents/citizens have access and availability as needed, without the barrier of affordability, at the point of delivery of the service. This is normally funded from the consolidated fund or general tax revenues appropriated for health services, not collected specifically for health care. The term national health insurance system or plan, theoretically defines a list of comprehensive and essential services which are covered by a mandatory insurance premium or plan which the government mandates to cover all residents and to which everyone must contribute; thus all are entitled to access care as needed without the barrier of affordability, at the point of delivery of the service. Universal health coverage, universal health or universal coverage extends the financial affordability and guarantee of a national health or national health insurance plan. It aims at securing access for all to appropriate promotive, preventive, curative and rehabilitative services at an affordable cost that secures financial protection with no fear of financial hardship or impairment. Nerdwallet, the USA consumer based financial analysts and advisors illuminated quite clearly the limitations of health insurance coverage and financial risk. Nerdwallet’s research in 2013, determined that health care is the biggest cause of bankruptcy in America: “Almost two million people will file for bankruptcy protection (from health care bills). Outside of bankruptcy, 56 million adults, more than 20% of the population between the ages of 19 to 64 years, will have major financial impediments because of health care costs. Fifteen million people have depleted their savings to cover medical bills and another 10 million will be unable to pay for necessities such as rent, food and utilities...more than 25 million people are skipping doses, taking fewer medications or delaying refilling prescriptions to save money.”
Health insurance, be it personal or national, does not eliminate financial hardships in seeking medical care. The required or desired government services may not be readily accessible or available, and the insurance copayments, deductibles or premiums may be financially constraining. In many developing countries, while government services may be available at minimal costs (as in the Bahamas), people seek private care, through direct, out of pocket expenses, for easier access or perceived better quality care. For many who can afford to purchase private care, they incur significant financial hardships.

A universal insurance coverage plan mandates a national health or insurance program to this higher calling of removing all financial impediments to access, availability and appropriate health care. It maximizes risk pooling, cost sharing, and greater financial efficiency and equity. Universal coverage undertakes the philosophy that health care is a public good, hence, a state responsibility. The individual’s monies can be invested in other economic endeavors, such as purchasing a home or higher education, rather than securing their personal health. Universal health coverage then becomes a vital tool for state development. So though well intentioned, national health systems and national health insurance per se, do not translate automatically or guarantee financial security from financial hardship. For many national health care systems, universal coverage remains the Holy Grail. With this clarity of nomenclature and ideologies of national health, national insurance and universal coverage, let’s return to the issue of who pays and how, and who owns and regulates these national health funding strategies.

What health care funding mechanism or model do we seek to emulate or create in the Bahamas? So first, what models are out there and what lessons can we learn?

T.R. Reid’s in *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care* classified the health care systems of the 200 plus world nations, of which only about 40 have established health care systems. In his treatise, he catalogued the countries’ health care systems into 4 major groups based on their funding models. The variations reflect the debate, culture and resolve to “meeting the three basic goals of a health care system: keeping people healthy, treating the sick, and protecting families against financial ruin from medical bills.” At one end of the spectrum was the British model type – a health care system predominantly
government owned and ran, and funded by general taxation. It’s a much-regulated system in which the government determines physician fees and the services the system will provide. Variants would be in Spain, New Zealand, and most Scandinavian countries. Cuba would be the purest form with complete government control and no private practice sector.

The German health system represented the other end where health care is essentially private owned, administered and funded; government serves as the regulator. Funding is by sickness funds, essentially reflecting a not-for-profit insurance, guild or union-based groupings called sickness funds in which employees pay premiums, half paid from wages and the other half from the employer. Government covers premiums for its workers and the indigent. Countries with variance of this model include: France, Belgium, the Netherlands, Japan, and Switzerland.

The Canadian system is a national insurance, one payer system; every resident must have insurance coverage, for a defined set of essential medical services. It uses private-sector providers, but payment comes from a government-run insurance program that every resident pays into. Each province has a small variation on collection, with each system reflecting components of both the British and German model.

The fourth type applies to countries where individuals are expected to pay out of pocket directly for care; this applies to most undeveloped countries with poorly available health care system and services. Reid emphasised “that most of the nations on the planet are too poor and too disorganized to provide any kind of mass medical care. The basic rule in such countries is that the rich get medical care; the poor stay sick or die. In rural regions of Africa, India, China and South America, hundreds of millions of people go their whole lives without ever seeing a doctor. They may have access, though, to a village healer using home-brewed remedies that may or not be effective against disease. In the poor world, patients can sometimes scrap together enough money to pay a doctor’s bill; otherwise, they pay in potatoes or goat's milk or childcare or whatever else they may have to give. If they have nothing, they don't get medical care.”
The consideration of these four types of health care models begs the question: Where are we now in the Bahamas with regards to health care? Are we there yet and if so, when or where do we want to go?

In our Bahamian health care system, there is certainly a bright side. Our health care system has certainly come a long way since the Princess Margaret Hospital (PMH) was constructed in 1952. When I graduated from medical school in 1980, there were an estimated 15 consultants in total at the PMH with 7 specialty services; today there are some 100 consultant level qualified physicians and 32 specialty services.

The PMH is the flagship of the government health care facilities featuring primary, secondary and tertiary care services. It is the trauma referral center, with modern adult and neonatal ICU services. All the modern diagnostic and therapeutic services are directly or indirectly available and accessible to all seeking care in the public health care sector. There are several vital services not available directly in the Princess Margaret Hospital, such as MRI scanning, open-heart surgery and radiation therapy. The government subsidizes most of the costs of radiation therapy for cancer care. In the case of MRI scanning and open-heart surgery, the government provides a partial subsidy when requested and means testing is applied by social services. This same policy exists for any services needed by Bahamians but not available in the public health care sector. There is provision too, though limited, for care sought internationally.

Currently, the PMH is being transformed from a service-based hospital to an academic one; this can only auger well for advancing medical care in the Bahamas. In 1997, the hospital was formally accredited for the teaching of medical students in the faculty of the University of the West Indies in their final two years of their medical undergraduate degree program. As of June 2014, there have been over 300 graduates of which 80% were Bahamians. In 2003, postgraduate medical training programs were introduced and to date, we have graduated 46 physician specialists.

In Freeport, the 70 bed Rand Hospital showcases an integrated health care system where the tertiary (hospital-based) health care system is integrated with the public health and community
clinic (primary care systems) on the island of Grand Bahama. Patients are referred to Nassau -
critical cases and other services not provided in the Rand Memorial.

In public health, there are over 100 community clinics throughout the archipelago. These clinics
are modern, well equipped, and staffed with primary care physicians, nurses and other health
care providers. They are distributed such that a Bahamian resident anywhere in the country is
within a 5-mile radius of having access to the services of a physician or nurse. In the family
islands, there is also a first responder service for local emergencies. The government contracts
an air ambulance service, on a 24-hour basis, such that the family island patients can have
emergency airlifts to the tertiary care facility in Nassau, whenever needed.

Prior to the onset of HIV disease and the resurgence of TB, communicable diseases such as
measles, typhoid, rubella, polio, and tetanus are of historical interest only, as we have a
population of almost 100% immunization. Today, malnutrition translates to obesity, over-
eating, as opposed to starvation where children and adults did not have enough to eat.

The government health care system is primarily funded through taxation, a spill-over from our
British colonial heritage. Patients using the government services are charged nominal fees,
especially a co-payment. The total revenue generated from nominal fees collected, amounts to
5% of government expenses for health care delivery. The government treasures its policy that
no one can be denied care because of inability to pay; it is not surprising then that less than half
of the nominal fees charged are actually paid.

Unfortunately, there is a dark side of our current health system. Over the past ten years, the
government’s spending on health care has increased significantly. Since our initial national
health plan in the 1990s, the government’s spending has doubled, $166.9 million in 2001 to
$314 Million in 2012. We have built and improved ambulatory clinics throughout the
archipelago, increased our physician and nursing human resource pools, made multiple
upgrades on the physical plants of our tertiary care institutions – even established a Hospital
Authority to improve efficiency and effectiveness.
Sad to say, our national health profiles with regards to our performance indicators have not been stellar. First, Bahamians are not living as long as they should, the infant mortality rate is too high; pregnant woman are not attending the free government clinics. Non-communicable diseases such as hypertension, diabetes, obesity, high cholesterol and cancers are occurring at alarming rates; heart attacks, strokes and kidney failure are our leading causes of death; the kidney machines are going 24/7 for those whose kidneys are damaged permanently. It’s costing our health care system almost $70,000 per year per person to keep them alive. Violence and injuries, all preventable diseases, are overwhelming the health care system as elective surgeries and medical conditions are becoming unmet needs. For the communicable diseases, while gleaming in our notable decrease in HIV transmission during childbirth, some of our defined population groups are spiraling in numbers again. TB is on the increase. Full stop, for now. The list is exhaustive; no need to say more, the Bahamas is a nation of very sick people.

And so we conclude, we need more money to restore our health, make it better, maintain our health and more importantly prevent sickness from recurring and commit to a wellness care initiative.

To do this, our new health system must, at the onset establish two targeted approaches: first, there must be a major focus to manage these chronic diseases better, while we simultaneously advance a major preventative health agenda.

The second is to implement all evidence-based measures to control and de-escalate the rising costs of health care. Every service delivered must embrace cost containment. This is the essence of chronic disease management and preventive health care: an ounce of prevention, continuity and integrative care, for a pound of cure.

As taxpayers or purchasers of health insurance premiums, we want the best value for our health care dollars and we must evaluate and monitor for the best results. The emphasis in our NHI debate must be focused on the bigger picture: how to fund the system, and how best to spend the funds. Which of the four systems above best suits our Bahamian ethos?
In both prior proposed NHI schemes in the Bahamas, the government selected the social insurance model (a German-based variant). Every citizen undertakes the responsibility to pay the cost for use of the health care services, and pays their individual or family insurance premiums required for the sickness funds: the employer pays half and the employee pays the other half. The premiums are pooled and it provides the funds from which the service providers are reimbursed. The government provides the premium for those who are unable to pay, namely, the elderly, the physically and mentally disabled and the unemployed. Those whose incomes were below a certain level would have had a 50% discount off their premiums, or pay none at all; the government would have paid for them. When those exempt categories were tallied, 52% of the population was exempted from paying premiums. To pay for this exempt group, an additional fund was to be raised through a health care levy (tax or charge – your choice of the label), on the traditional NIB payments in which again the employee would pay half and the employer the other half. In the first proposed NHI, at least the minimum package of benefits could be sold by the private insurance carriers who would have the flexibility to add supplemental insurance for additional benefits not covered in the basic package. Bear in mind that the basic package applied only for services rendered at PMH and reimbursed at cost determined for PMH services. Private care would require supplemental insurance. Not covered in the basic package of services were: private physician services, private pharmacy services, private laboratory and imaging services except for CT scans and private dialysis services - these two were covered. These initial, non-covered services would be phased in at some later date to be determined.

In the NHI proposed in 2006, there was a 360° turn-around. All services were covered, from cradle to grave – it was a reenactment of the British National Health Service introduced in 1948. There were few non-essential services, such as cosmetic surgery. The big issue here was that government would be the only collector and payer in town; private insurance carriers could provide supplemental insurance coverage only and were not allowed to provide insurance coverage for the basic packages of services administered by the government. It was a true hostile takeover of the insurance industry indeed.
The linchpin of the pros and cons of the social insurance system is centered on the unemployment rates; if most people are employed, this is an ideal system. However, with the high rate of unemployment in the Bahamas, implementation and sustainability of a social insurance based system pose serious concerns. So how do the other models of national health measure up for the Bahamas?

The Canadian one payer system has the merits of a low administrative cost in a one-payer system. The essential health services provided are comprehensive; there is choice, equal access, availability, and equity - those who need get what they need and those who need more get more. There is great effort to apply these principles across the vast Canadian plains as well, minimizing the geographical barriers to access as best as possible. These measures would be ideal for the archipelagic nature of our Commonwealth. The Canadian Health Act prohibits private insurance carriers from providing the core essential services. The Canadians give high ratings to their health care system; they love it. But in Canada, they pay income tax and it’s significant.

This socialized medical concept has its critics, particularly from their neighbors to the south, the USA. There will always be opposition to a government administrative process as the single payer, particularly one as huge and complex as health. Government agencies are perceived often as a bureaucratic albatross, lacking accountability, transparency and flexibility to accommodate change and innovation. Moreover, an essential service without a private option is an unthinkable scenario and the Canadian (and British) system manifests the worst of socialized medicine – the waiting times! It’s the rationing of care. When everyone is equal and has equal opportunity and the supply is limited, everyone lines up. First come first served. The end of the line could be 6 months, maybe even a year or more in some cases. This waiting issue has lead to online access to see how long it would take to receive care. It’s what triggered the breakthrough for private medicine in Canada: the Supreme Court declared that it was unjust for a patient to have to wait over a year to receive a medical service, suffering in pain in the process without the option for an alternative service. There are lots of lessons for us to learn here coming from our American consumer-influenced community.
A paying out-of-pocket system is predominantly what we have now. Private insurance coverage is plagued with costly premiums, deductibles and copayments which many cannot afford and therefore, have limited or no access to care. Many who can afford to purchase care directly out of pocket do so at a great financial sacrifice, depleting their accounts and reserves; a significant number declare bankruptcy.

We inherited a British health care model; they reformed theirs in 1948. Sixty-seven years later, we are still seeking to reform ours.

The British system, the National Health Service, like the Canadian and those adopted by the Organization of European Cooperative and Development, is funded primarily through income taxes. To implement this funding initiative is perceived as political suicide; the phrase “income tax” is taboo in the Bahamas. Our entire financial services industry, our second major industry is based on no income taxes. Unlike the Canadians however, the British do have a two tiered system; if you don’t want to queue, one has the option to pay for private care and move to the front of the line.

A note on the American system, God helps those who help themselves. Over 50% of the population has help: those who have employment have private health care benefits, senior citizens enjoy the benefits of Medicare and the poor have government aid, Medicaid. It’s a country where individuals and companies pay income tax and it’s the tax rebates that cover health insurance premiums again. This still leaves an estimated 15% of the population unable to afford health insurance coverage.

Health care in the USA does not come cheap. At the highest per capita spending in the world, at twice that of the average of the OECD, even those with health insurance coverage can incur catastrophic health care costs from required out-of-pocket insurance expenses. Imagine those where the entire costs are out-of-pocket.

So here is our challenge: How do we generate revenue to cover the costs of providing health care services for our Bahamian people? And one that measures up to the quality of care we
have come to expect as our neighbors to the north: First World medicine – only the best will do!

There are certain realities we must acknowledge up front in the debate:

1. We must not lose sight of the fact that the Bahamian people are already paying megabucks for health care services - currently, 250 million dollars, 15% of the government budget, we pay already through our taxes. It’s not that the government is giving us something for free that we now have to pay for; we have paid for it already.

2. New monies for health projects to more taxes. Our indirect taxation is already a major burden; the corporate community and the middle and upper class income earners feel the brunt of it. Concerns of additional taxation leading to diminishing returns and economic stagnation are real. Consider the additional expenses and increase over the past 5 years to do business in the Bahamas:

   • Business license fees
   • Facility license fees
   • Professional registration and license fees
   • NIB social insurance payments: add-ons
     o Unemployment
     o Pharmacy
     o Solvency prevention
   • BEC Utility costs
   • And now VAT.

An inflationary economy looms in the midst of a population where 20% of home mortgages are in arrears. The cost of doing business in the Bahamas is high; we are losing our competitive edge on the region.
Now we are about to add health insurance – an additional business expense if we are to introduce the social insurance scheme, or just increase current NIB contributions, both of which the employer pays 50%.

3. Bahamians are major consumers of everything, including health care. The system must build in cost containment from the onset. We will be riding the waves of the American exponential growth of health care costs without the benefits of a healthier population to show. In the developed countries, many have better health outcomes at half the costs.

4. The great waste in our health care system. It is estimated by the Institute of Medicine that over $700 billion dollars is wasted in health care delivery in the USA. In the Bahamas, our health care system can be defined by all the elements of wastage outlined by the IOM in the USA: Lack of care coordination, lack of effective prevention and health promotion programs, high absenteeism and inefficiencies. Many would question whether we need any new revenue at all – we just need to get rid of the waste! We need to get value for money. This would be a great argument, if only it was so simple. It cost money to get rid of inefficiency and waste too.

5. The value of Public-Private Partnerships: Much capital is required if we are to establish health care services in the realm of modern medicine. Medicine does not come cheap. Medical care is expensive and quality medical care is damn expensive. The new imaging technologies are multimillion ticket items and new drugs such as life saving cancer pharmaceuticals are extremely expensive. So, too, is the cost of the new health providers: physician specialists, nurses, the allied health professionals, health care managers and administrators. Vocational and health education expenses are costly and many health care providers face significant student loans long before graduation. Our current government revenue already accounts for over 80% personal emoluments. Where will we get the revenue to pay for all the new staff required?

This is where public-private partnerships have great merit. When we travel to Miami to shop and we need transportation to move around for a few days, we don’t lease or buy a car; we rent one. The money allocated for travel is consumed purely to acquire the services of transportation, not its ownership. Could we not consider health care services the same way?
Rather than the burden and expense of owning, operating and maintaining an MRI, the government may see wisdom in purchasing only the services. This can provide major savings. It is imperative though that in its outsourcing of select services, the government must be a prudent negotiator and with the best interest of the Bahamian public. When the deal is done, the government can’t pay more to rent than to own. Incentives, performance measures, accountability and transparency must be the order of the day.

Outsourcing, the promise of economies of scale and tax incentives could project for significant reduction in costs, rendering defined health services provided more efficiently and effectively in the private sector, in a public – private partnership. The people can get real value for money: getting more and better care for less.

6. The need for institutional strengthening and infrastructural advancement prior to implementation. The people need more than a promise if they are to spend more for what they get now, especially noting the realities that as tax payers, they have paid already for services they are receiving. There is a lot more that needs to be done before implementation. There is a new critical care block – it needs to be functional and to demonstrate its effectiveness and efficiency. The PMH and the Rand need to be upgraded for inpatient care; the open Florence Nightingale wards are outdated. Medical records and the modes of documenting, retrieving, storage and access to patient information must be upgraded. There will be no improvement in coordination and integration of care without better medical records. It is untenable for any modern health care system not to have an electronic medical record system. We need to inculcate a culture to eliminate medical errors and improve patient safety. We need to advance modern scheduling programs to decrease waiting times for clinic appointments, hospital admissions and surgical procedures.

Designing a health care system for the Bahamas is a major challenge. We have no income tax and seek to extract more from a population with a culture of evading taxes and who perceive they are overtaxed already. Significantly more funds are needed to pay for advanced technologies and pharmaceuticals, upgrade of services and the physical plant, and the increasing costs of more skilled and specialized physicians, nurses and allied health providers.
These are the fixed costs; the variable ones – higher expected utilization and the impact of consumerism in our choice of medical care services are yet to be added to the equation.

There is a possible windfall in savings if we could eliminate the waste in the delivery of our services, better coordinate and integrate our chronic disease care and foster health prevention and promotion as the foundation of our delivery system. These, however, are not insignificant costs and need capital infusion as well.

What is evident to me is that none of the 4 health care models are applicable to the Bahamas, not by even a stretch of variability. We are seeking to emulate and design a health care system but we are at a starting point, which far supersedes that of any existing health care system when they were created. While we recognize the need to improve our health and our delivery systems, the elephant in the room asks the question – why do we need a new national health insurance system? We have one now – it just needs to be reviewed, revised and reinvented.

The introduction of national health insurance programs is driven historically in countries due to lack of accessibility, availability and affordability of health care. In the USA, while the poor, unemployed and elderly are covered by the Medicare and Medicare systems, over 40 million people have no health care insurance coverage- primarily employed individuals who cannot afford the insurance premiums. (The Affordable Care Act seeks to reduce this uninsured population and the initial results are showing much promise.) The introduction of national health insurance in Germany in 1883, emerged from the great need for affordable health care for the exploited “lumpen proletariat” created in the industrial revolution. In Great Britain, the National Health Service was the answer to the health care woes after the World War II; Canada with its vast land mass, indigenous peoples and need for affordable access and availability of care for all, entrenched these desired principles in its Canada Health Act in 1973.

The rationale for introducing a national health insurance scheme in the Bahamas is one of equity and affordability. People when in need can’t get the care they need when they need it, due either to (i) the shortcomings in the public health care system – shortages of supplies, lack of equipment availability or just overwhelmed and underfunded services, or (ii) because they
lack monies to pay for care directly out-of-pocket, or for private insurance coverage or can’t afford to pay the extra charges.

With everyone mandated to contribute, the NHI will spread the risk and thus reduce the costs of health care premiums and improve access for everyone. There will be more monies available for funding to purchase required equipment, supplies, and to finance the desired institutional improvements that will lend to more efficient health care delivery, and thus patient outcomes.

Will national health insurance improve access and equity in health care in the Bahamas? Are our health care woes a matter of more funding? How much funding is needed and will we ever have enough? Herein is the proverbial question of any national health insurance scheme. We must acknowledge that health care in 2015, is no longer a simple matter of an essential need and having the resources to meet that need, it’s about choosing a desired health care option. Health care has been transformed to a commodity; as such, it conforms to all the characteristics of a market product. It’s a paradigm shift and sets the stage for the final in this series on health care:

**The Buyers & the Sellers: The Economics of Providing Health Care for Developing Countries.**
Part 3

The Buyers & the Sellers: The Economics of Providing Health Care for Developing Countries.

Swallowing the bitter pill of high medical bills
The Buyers & the Sellers: The Economics of Providing Health Care for Developing Countries.

**THE HEALTH CARE CRISIS:** Health care cost is spiraling; it has outpaced inflation and it has done so at the budgetary expense of the other essential goods and services. In 2010–11, Canada’s province of Ontario spent $44.77 billion on health, 40.3 per cent of its total spending on programs. Based on current trends, this share is likely to expand to more than 44 per cent by 2017–18. (Commission on the Reform of Ontario’s Public Services, Ontario Ministry of Health). Canada’s 10 provinces and three territories currently combine to spend an average 36% of their budgets on health care. Health Care spending in the United Kingdom in the past 20 years, has more than doubled in real terms and outstripping all other major public spending, £57.6bn ($87.7bn) in 1993-94 and that by 2013-14 it had reached £129.4bn (US$199.1bn) (the Office for National Statistics). Note how quickly the government of the Bahamas spending has doubled, $166.9 million in 2001 to $314 Million in 2012.

How much we should spend, who should spend it and where should the money come from has emerged as one of the great debates of the new millennium. The financial discourse is at forefront of every political and national agenda and for many, it’s a personal economic reality too – people can’t afford to pay health insurance premiums, even more so upon retirement.

In countries where private health insurance plans are predominant, the uninsured numbers are increasing; individuals and families are unable to afford health insurance premiums. Companies providing employer based health insurance benefits are challenged to maintain their profits and competitive advantage as health care costs spiral; less employees are being covered and the extent of the coverage is decreasing.

In public sector funded health care services, budgetary constraints due to increasing health care costs have resulted in health care rationing; there are long waiting times for physician and clinic appointments and for both diagnostic and therapeutic procedures – it’s a recipe for unfavourable outcomes in health care delivery. People die waiting to receive care.

**There is a crisis in health care and the central issue is containing rising health care costs.**
It is not for want of solutions. The managed care model introduced in both private and public sector care had its moments of success. There was improved efficiency and quality of services and health care costs showed decreasing trends. Once this was optimized, however, the substitution of managing cost through limiting care was unraveled and health care costs resumed its exponential path. The promising public-private partnership models have eased the financial constraints on public sector budgets, but not necessarily decreased national health care spending as a percentage of GDP. The ethical and political issues regarding privatization of health care services remain a topic of hot debate.

Another recent trend is the shift to prevention and wellness programs in light of the onslaught of the lifestyle related, non-communicable diseases. These programs, however, are not inexpensive, and one cannot ignore the argument that we are merely shifting costs to end of life care.

The debate on solutions to providing affordable health care will only intensify. The population is aging; our senior citizens utilize more health care services and the costlier ones at that. Of even greater concern is the shrinking working force. This is more paramount in the developed countries where fertility has plummeted through better reproductive health and family planning - the dependent non-working population and, in particular, the aging group has outstripped the taxpaying working force. There are dire predictions for lack of available health care dollars for the post-World War II baby boomer populations because of the explosive need and cost for health care services. In Ontario, the Institute for Clinical Evaluative Services. estimated that 1% of patients, 80% of whom are over age 65, account for 34% of total health care costs. 5% of the population accounts for 84% of combined hospital and home care costs.

**DEFINING MEDICAL CONSUMERISM:** The success of any solutions to resolve this health care crisis must refocus on the issues underlying the increasing costs of health care and how to control them. So what has been the major factors contributing to rising health care costs?
The technological and pharmaceutical advances take center stage. There is little to debate here, these two budgetary items are vital to our longer life spans and improved quality of life. Managed care and private public partnership have made major inroads to improving efficiency, utilization and curtailing costs. The malpractice issue is being addressed through advancing risk management programs and limiting settlement amounts through legislation.

This essay proposes that medical consumerism, the desire to want and consume more health services, especially if a third party payer foots the bill - yielding to the perception that health care is free, is the primary engine fueling today’s costs in the health care industry. Someone else is paying the bill; so let’s get it all and only the (perceived) best will do.

The attention on curbing health care cost must focus on what could be proposed as the most significant paradigm shift in health care in the past 50 years – the transformation of health care from an essential service model to a health consumer product and manifesting all the classical features of the product life cycle experience in the field of marketing. The analogy is liken to a shift in Maslow’s hierarchal structure from a level one basic physiological need to a level four, and ultimately a level five – self actualization. In the words of Sir Thomas Moore: *health is the greatest of bodily pleasure.*

**IS NEWER BETTER?** We have become consumers of health care services, with little regard for the effectiveness of the product, particularly in regard to its utility compared to other available products. The medical literature is inundated with examples of our products in the human market, each proclaiming to be the latest and the best. This is exemplified readily in the treatment of prostate cancer; the options are numerous and so are the varied costs.

The progress and benefits to treating prostate cancer are testimonials to the medical advances of the last century. In the surgical arena, there are the benefits of the minimally invasive techniques – pinhole surgery or no scars, less pain, shorter hospital stays, earlier return to regular activity and longer lifespans. In radiation, there is External Beam Conformal Therapy (radiation from the outside), Brachytherapy (radiation from the inside), IMRT (Intensity Modulated Radiation Therapy) and now Proton Beam Therapy. The non-radiation treatment programs are flourishing too: Cryosurgery and High Intensity Focused Ultrasound. The newer
modalities are all at prices exceeding the costs of the traditional open surgery. But are the marginal benefits cost effective? Are we getting value for money spent?

The new toy on the market is the Robot! Within two years of its introduction, the Robotic technique accounts for over 60% of the radical prostatectomy procedures performed in the USA. The proponents of the Robot laud its numerous advantages over the open procedure: a shorter hospital stay (– one day on average), and the need for less analgesia (– one day too) and less bleeding (– but not leading necessarily to less blood transfusion). But for the two major complications of the paramount concern, however, control of urination and return of sexual function, there is no advantage. In the era of health care cost restraint, can one justify purchasing a $1.5 million machine with a $100,000 per annum maintenance costs, when no new capital outlay is required for the traditional standard open surgical procedure? But to remain competitive, the hospital must have a Robot and the surgeon must be able to market to the public that he/she does the Robotic procedure.

The patient wants the latest and the best treatment and expects that the outcomes are superior. Far from it! The technology and marketing is driving consumer choice. A Google search of “Da Vinci Robot” yields over 35,000,000 hits; the public is being inundated. The marketers are in full swing. The Robot is rapidly being deployed for new diseases to conquer: in gynecological surgery for hysterectomy, general surgery for bowel resections and now open-heart surgery too. The other treatment options for early prostate cancer that yield marginal better outcomes, at best, are being marketed heavily too.

Now a new debate has surfaced that prostate cancer is over treated; the use of PSA for early detection is diagnosing an early cancer that is not harmful, and need not be detected or treated. **The facts are that the patient is overwhelmed with a shopping list of expensive products to treat the prostate cancer that may not need to be treated in the first place.**

**DOCTORS PEDDLING NEW PRODUCTS:** Let’s not neglect the other side of the health care equation, the doctors. The sacred trust that is embodied in our profession, the social contract – to place the patients’ interest above that of the doctors’, leaves much to be questioned. The conflict of interest issue is huge and pervasive. The potential to make more income with higher
reimbursements for new technologies and particularly as the first kid on the block with the newest and latest toys – is overwhelming. Physicians are driven by higher charges and collections. To enter into the market place before reimbursement codes are regulated is most tempting. The “big centers” have the competitive edge and are setting and defining the goal posts - how many procedures need to be observed and proctored before one has the “right” to be practicing independently?

This amounts to the practice of medicine being dominated and driven by all the forces of consumerisms: the industry to market and sell the new technology – the latest and the best; the physician to earn more through selling the service and doing as many as possible; and the patient who has been enticed through marketing and advertising to have the latest and the best. Health care cost for the surgical treatment of early prostate cancer has spiraled through the roof. This scenario is replicated for many diseases diagnosed today.

**THE CASE AGAINST FEE-FOR-SERVICE MEDICINE:** From a financial perspective, the consumerism issue is underscored by one dominant fact: the more the service is used, the more monies are spent. The vicious cycle of fee-for-service on the impact of health care, more utilization, more fees, more monies spent, has to be broken. Paying for performance and value base payments have become the new solution being peddled on the block.

The new frontier of reimbursing for patient outcomes to a group of health care providers, who are coordinating and integrating health care services, has to be the way to go. It breaks the cycle of fee for service medicine, and meets all the suggested recommendations of the Institute of Medicine, to curtail the costs of health care.

Of equal importance is the new approach to the incorporation of new technologies as the diagnostic or therapeutic standard of care. They must be evaluated first within the context of the real value that they bring to the health care market. This is particularly true for the developing countries with limited health care resources.

Back to our original debate, how do we provide quality care at an affordable price?
**PAYING FOR CONSUMERISM**: The solution at its core must reestablish and itemize an essential core of health care services. These core essential services must reflect the standard of care underscored to be the most cost effective and proportional to the capital investment and human resource demands. The investment of a traditional nerve sparing radical prostatectomy with a capital cost for equipment of less than $10,000, can’t be measured simply by a one day shorter stay in hospital, one less unit of blood and one day less of analgesia when trying to justify a capital investment of $1.5 million for a Robot, especially considering the need to create a new physical site, training and maintenance. The selection criteria for a diagnostic or treatment plan should mimic the initial principles of the Oregon plan; those who are paying for health care must be informed of the relative costs of the procedures and through public consensus determine the standard of care to be adopted. The health care providers’ role must be minimized due to the conflicting interest; we are only to provide the scientific facts of the pros and cons, and the evidence to the effectiveness, efficiency and value.

In these core services, reimbursement is predicated on population outcome measures; a group or network of core health care providers contracting with the payers to provide the services and producing the evidence that the care is efficient, effective and better the health of the defined population for which care is being delivered. There cannot be fee-for-service delivery, simply do more and earn more. Incentive reimbursement is agreed to on the basis of patient results. In fact, there may be penalties depending on failure to achieve the desired results.

Patient choice and options for services cannot be denied; there must exist a parallel health care service in which patients can choose whatever they desire – the tenant of consumerism and the right to choose must be available, but at the patients’ expense, not that of the payer for the core group of services. This ensures a stabilizing of prices for the core group of services.

The treatment of advanced prostate cancer exemplifies the issue of essential versus desired care and the impact of consumerism on costs. Let’s review treatment of advanced prostate cancer in which the standard of care is hormonal ablation – the elimination of testosterone produced by the testes. This can be done medically using drugs or surgically by removing both testicles. The drug treatment plan is required indefinitely until the cancer recurs or the patient
dies; the surgical plan is a onetime expense, a minor outpatient procedure. Computed over a five years course of treatment, the medical route is 30 times more expensive. If the more recently advocated “total” hormonal depletion program is applied to the pharmaceutical route, (shown to be of minimal or debatable advantage) the cost increases by 40 fold over the surgical route. 

There is no difference in outcomes in the use of drugs versus surgical treatment with regards to living longer or failure of treatment. The cited reason for medical option over the surgical one is deemed to be psychological - the mental anguish of having one’s testicles removed. Both have the same outcomes vis-à-vis, loss of sex drive and impotence, both produce the side effects of testosterone withdrawal syndromes. Moreover, the research for the advantage of the additional drugs for the total hormonal castration remains a topic of much debate, as to whether there is a significant increase in longevity. It is interesting to note, also that, over time with the drug treatment, the testicles will atrophy, virtually disappear as if surgery were performed.

Why spend millions of dollars simply to pacify the (perceived) psychological needs of the patient, for the same outcome several years later. Is it that the medical plan is more profitable? Major cases in Medicare fraud for doctors using medical therapy are well documented. Or is this just another consumer product driven by aggressive marketing by the pharmaceutical industry? What is it that we are actually paying for? The budget can only be expected to spiral as the aging population rises and prostate cancer remains the most common cancer and the most common cause of cancer specific deaths in our male senior citizens. Drug treatment for advanced prostate cancer is a consumer choice. Shouldn’t this cost be paid directly by the patient and not the group?

The principles of two parallel systems, a product line of basic care services and a consumer driven one, is underscored by the culture and economic norms of a country and the community. The British National Health Services have adopted these principles in a rudimentary form. You can opt to receive care at the National Health Service facilities, funded by the government taxes, or one can receive the convenience and upscale product of the Harley Street
private concierge health care. The national health services provide equal access to the appropriate; individuals receive the medical care as needed care. Alternatively, they can opt to pay for the Harley Street concierge services.

The core of essential services, however, are patriarchal based, the citizens have very minimal direct input into the services to be provided. The recent spiral increase in the costs of services from the Pay-for-Performance program in the NHS is unfortunate and shows the weakness in reimbursement in a fee-for-service program; the outcomes that defined the benchmarks for the GPs, should have been the standard of care from the onset.

In the Canadian one-payer system, the Supreme Court has already set the stage for consumer driven private care programs. Public-private partnerships should do well to reduce the demand on the provincial health care budgets. A universal one-payer system is entrenched via Medicare and Medicare in the traditional American private insurance-based health care. But the American universal one-payer system has not reflected the cost containment administrative effects of the Canadian system. The implementation of the DRG (diagnosis-related group) system of care had a major effect on containing and decreasing health care costs in the Medicare and Medicaid services. The DRG initiative incorporates the hospital and physician charges as a package deal, thus removing the fee-for-service incentive for all the providers. What needs to occur is the marriage of the DRG to population outcome measures.

Developing countries can undertake a leadership role in providing quality care at an affordable price. Without the capital funds for expensive new technological advances, the traditional standard of care services must measure, firstly, the value and merits of implementing and incorporating these new services. In most instances, the government is the major payer and provider of health care services. Health care providers are employed directly by government; health care physician services are prepaid.

Public-private health care partnerships are fodder for developing shared health care services: the private sector provides the capital, maintenance and human resources; the government becomes a purchaser of services required, without the burden, complexities and potential inefficiencies of ownership. The merits and issue of national drug programs in developing
countries has long preceded the current interest and thrust for national drug programs noted in the developed countries.

In summary, the developing countries of the English speaking Caribbean are laboratories for evaluating health care systems and cost containment. Through social and educational programs, our literacy rates and health care profiles have approached those of the developed programs and at a fraction of the cost. To establish a core package of affordable health services with universal access is essential to our survival. The ability to control the costs of consumerism in health care is the new frontier in health care.

One is reminded of the principle of taking a transatlantic plane ride. One can choose to fly first class with all its amenities – early boarding and disembarkation, a choice of meals, unlimited drinks, silverware, big comfortable reclining seats and personalized service, compared to the smaller seats and limited amenities in economy class. What is important, however, is the safety of the ride. Both economy and first class passengers will experience turbulence but both classes will get there safely and at the same time. So, too, we need to distinguish that the principal factor in the delivery of the health care service is the safety and quality of the care and not be charmed by the service amenities.

What are we getting when we seek health care services - perceived unrealistic expectations, unsubstantiated outcomes and the sales pitch of manufacturers and vendors? What is a “medically necessary” health service? In a USA Today feature on cosmetic surgery in children, Dr. David Staffenberg remarked that To one person the term may refer to a life-threatening condition, while another may consider it something that interferes with daily activities or a health self image. Separating the consumerism in health care – distinguishing between our wants and our needs is essential in controlling the rising cost of health care; the provider and product must be held accountable. Let the buyer beware.
Conclusion

I entrust that this series of articles are informative, enlightening and sparks your interest to be involved in this national debate. As the Bahamas moves forward on this journey to a national health care coverage, it seeks to provide for each resident the right to health care and for those who need care, get the care they need and those who need more, get more, in a timely manner while minimizing the risk of financial impairment. This does not come without significant costs, and even greater efforts are required to maintain the costs of care at affordable levels. But like religion, how best to restore and advance our well being, defines our philosophy of life. At one end of the spectrum, your health is your personal responsibility, your choices and thus, your expense. On the other end, the philosophy maintains that your health affects us all, we don’t live in isolation - health is a community effort, a common good; we must share the cost and the risk.

In the modern era of health care, the delivery of health services and the economics of health care are inseparable and intertwined. The demand for health care is infinite, but the funding is finite. As the Bahamas moves aggressively to be the first sovereign country in the English-speaking Caribbean to implement a national insurance program, it is imperative that we acknowledge and understand the complexities of a national initiative in delivering health care. What are we getting? Who is providing it? Who is accountable and for what? Who is paying, for what and to whom? What is this really costing us? What happens if the money runs out? Inform yourself and let your voices be heard.

Your life depends on it.