Bahamas Dental Association's Position Paper on the Proposed National Health Insurance Plan

August, 2006

The Bahamas Dental Association (BDA) has deliberately withheld its official position on the proposed National Health Insurance initiative pending:

1) A closer analysis of the issue, with consideration given to the health needs of the Bahamian public;
2) An assessment of the present health care system, and its performance in trying to meet those needs;
3) An examination of pertinent positions and facts about NHI, and existing systems like it, advanced by various entities, both local and foreign.

Firstly, it is imperative to establish that the BDA advocates any effort that seeks to tangibly strengthen the state and delivery of health care in The Bahamas, without submitting to any vested interests or countervailing influences, which might prejudice our position at the expense of the welfare of the Bahamian public. We do not venture to suggest that the government come up with the perfect health care plan, as that is an unrealistic expectation. We do, however, expect the government to advance a well conceived plan that is sustainable, and which would achieve the objective of improving the quality of health care in our country.

The BDA believes that access to quality health care is a critical component in the development of any country aspiring to first world status. Any national health care policy that does not advance quality health care as vital to the continued growth and development of the nation, does so at the risk of severely impeding its growth, and at the extreme, causing societal fomentation leading to social instability and insecurity, where public health and safety are threatened.

With this in mind, the BDA understands the interest of the government in promoting universal access to health care. However, we question the government's haste in trying to implement a plan fraught with weaknesses, limitations and unanswered questions, before properly apprising the public of what, if any, real changes will accrue, other than an additional tax to their income and unrealistically heightened expectations of accessible and equitable quality health care.

The present governmental allocation toward health care in this year's budget is $205 million. According to the report by The Blue Ribbon Commission (BRC), $36 million in services were rendered at Princess Margaret Hospital (PMH) in 2003, however, only $6 million or 18% of this amount was collected. Curiously, when one combines this $30

million collections deficit with this fiscal year's allocation for The Ministry of Health (MoH), it is equal to the $235 million that the BRC purports NHI will cost annually.

Under the BRC's plan, government will contribute $111 million, or 47% of the estimated $235 million cost of NHI in its first year, whereas the public (employers, employees and pensioners) will pay an additional $124 million (53%) in out-of-pocket costs to fund this program. Although this represents $124 million extra dollars to the consolidated fund, only $30 million will be added to service the country's health care needs.

The BDA is concerned that the proposed NHI will result in a significantly increased health care budget with little or no tangible improvement in the quality of health care in The Bahamas. This would be a major tragedy indeed. The BDA requests that the government, being one that avows the virtues of consultation, provide material information about the kind of health services that will be included in this NHI plan, prior to proceeding with efforts to enact it into law.

What specific services will this plan provide to the Bahamian people that the public system does not presently afford them? What, if any, improvement in health care coverage will the privately insured receive, that would justify the loss of their private policies? Beyond acknowledging that NHI is a noble concept, without these requisite details, it is impossible to accurately quantify the quality of this initiative.

According to the BRC, in 2001, $343 million was spent on health care, inclusive of both public and private financing. Armed with this information, how does the BRC simultaneously suggest that $235 million will provide the kind of comprehensive care that they propose, without almost immediate and frequent increases in contributions by all stakeholders?

For a case in point of government's inaccuracy in estimating the cost of health care in the creation of public policy, one needn't look further than the contract entered into between the government and Physician's Alliance Management Ltd. (PAML) in 1995. Under this ten year partnership agreement, the Public Hospitals Authority (PHA) would provide premises, utilities and human resources among other things, allowing PAML to provide private health care services. The agreement called for the net profits derived from this public/private partnership to be evenly divided.

This contract is presently under review by the government, as figures as recent as 2003 showed that the government incurred a $553,903 loss. As stated by the BRC, "the existing agreement does not generate sufficient income to cover costs". When one compares the return on investment ratio in this equity partnership, one realizes that of the $3,189,195 invested by the government in 2003, the $553,903 loss represents an approximate 17% shortfall.

We cannot help but extrapolate how a similar 17% miscalculation of the costs for implementing the proposed NHI would impact its potential real cost. A 17% deficit

would equate to an underestimation of some $41 million, meaning that Bahamians could very quickly be asked to pay an additional $328 per year in contributions.

The prospects for gross inaccuracies in the NHI cost estimates are increased due to poor record keeping within our public health care institutions. In conducting their costing exercise, the BRC notes that statistical and financial data have been "difficult to acquire", and has forced management in the public health system to employ guess work, when making critical decisions. Without reliable data about the country's utilization of the health care system, the reality of such poor record keeping begs the question: How can we accept the estimated costs of NHI with any reliability?

Unreliable guess work results in the misappropriation and wastage of public funds. Our health care industry can ill-afford such guess work to be exercised in the development of a plan that has such far reaching implications. We therefore caution the government about hastily pushing this plan without first ensuring that the proper costing exercises are completed. This would minimize the future risks and distress caused by making grossly conservative estimates.

For NHI to succeed, the management of all hospitals and clinics will require significant organizational oversight to facilitate proper data entry, while also ensuring that there is financial compliance at the point of service by non-subscribers, prior to the delivery of health services. If non-subscribers are allowed to circumvent this requirement, it will very easily undermine NHI, by making it more costly to its paying subscribers. This is a legitimate concern considering the poor revenue collection that has been synonymous with the public health system. A substantial investment in information technology and health care management software are crucial to the initiation of this plan.

Not only will such technology be critical from a financial perspective, but also for the kind of medical record keeping that is inherently necessary for a health system consisting of multiple points of service, spanning multiple islands, designed to provide different levels of treatment. Tertiary level care (emergencies and complex treatment) provided at the two major hospitals in New Providence and Grand Bahama, requires immediate access to a patient's electronic medical records, taken in their primary care clinic.

Has there been any determination as to the amount required for capital expenditures in this regard? Doctors Hospital Health System, recently spent upwards of $5 million on such technology, and has an operation that pales in comparison to the scope of the government's NHI plan. Any health care strengthening plan should have already factored this requirement into its costing analysis, with an intention to effect its procurement and implementation expeditiously.

Bahamians have voiced concerns about the added costs of NHI, and the potential for utilization of its services by illegal immigrant non-subscribers. Bahamians have grown frustrated with having difficulty accessing health care facilities due to competition with the illegal immigrant population. The MoH and NHI representatives have insisted that

such concerns are unfounded, as all NHI non-subscribers will have to pay at the point of service, before receiving treatment, except in the event of certain emergency scenarios, when it would behoove the government to treat illnesses that threaten overall public health.

The recent malaria outbreak is a case study in support of this policy, to guard against vector transmission of communicable diseases, introduced to The Bahamas by carriers emigrating from countries where such diseases are endemic. The costs incurred by the introduction of such diseases have both a direct and indirect effect on our economy, by adding financial burden to the health care system and the Bahamian taxpayer, while serving as a deterrent to tourists fearful of contracting the illness.

The BDA understands that our nation's policy is not limited to the impact of public health crises on our country's national security, but extends to our nation's obligations to various human rights accords, which compel us to provide certain essential services, aside from emergency care, whether or not payment is made. Child labour and delivery, is one such essential medical service, and one where illegal immigrants have contributed to the frustrating shortage of hospital beds experienced by Bahamian women during recent times. Such obligations denote the unreliability of the BRC's claim that immigrants will be forced to pay for health care services under NHI. The humanitarian concerns will still be the same in the future, and will continue to compel the government to provide health care to non-subscribers, regardless of whether or not payment is made.

The BRC makes frequent reference to the need for cost containment if NHI is to be sustainable. Such cost containment is adversely affected by uncontrolled illegal immigration. This underscores the dependence of NHI on effective immigration enforcement, to prevent illegal immigrants from entering The Bahamas, and to immediately repatriate offenders before such challenges occur.

We must also examine the desire by businesses to contain costs, in an effort to remain competitive in their respective sectors. As employers face the prospects of absorbing additional labour costs, one of three results will accrue:

1) Real wages will decrease
2) Costs of goods and services will increase, without a change in wages
3) Employers will implement cost cutting initiatives (cutting jobs) to remain competitive, without decreasing real wages or increasing the costs of their goods and services.

None of these would have a favourable impact on the Bahamian economy. The concern is that government insists on not characterizing NHI as a tax, when in actuality it will either decrease the real wages of the average Bahamian or increase the costs of goods and services to Bahamians and tourists alike, raising the already high costs of living and doing business in the Bahamas. It is worthy to note that we are contemplating increasing the cost of labour, at a time when there is grave concern within the private sector, about the dearth of qualified skilled workers available to meet the demands of an expanding

economy. Government wants small businesses to invest scarce financial resources, resulting in an increase in the cost of labour, at a time when many potential employees lack the requisite skills.

Such a dichotomy is inequitable and parallels the dilemma being realized in The Ministry of Tourism, where one of the greatest challenges is said to be offering visitors value for money. Indeed, if businesses are forced to adopt the second of the three options listed above, The Bahamas would be further disadvantaged if costs continue to increase disproportionate to the level of service.

The BDA is left to ponder whether the added cost of labour may deter prospective employers from hiring new workers or prompt them to justify eliminating the jobs of some of their current employees. Said differently, will the introduction of NHI, combined with our country's overall poor level of educational achievement, force small businesses to make difficult decisions that would contribute to greater levels of national unemployment?

The potential negative impact of not containing costs, or of underestimating costs, will force the government to make some very difficult decisions about increasing subscriber contributions to NHI. The BRC recommends that any changes in contribution rates should be made by parliament. The BDA asserts that the resultant conflict of interest would very likely paralyze government's will to effect any such increases, for fear of upsetting the Bahamian electorate. Therefore, it is not unreasonable to expect that the NHI could very likely suffer from a lack of funding due to political pressures, further worsening the realities of socialized medicine – rationing and extensive delays prior to treatment – as experienced in countries like Canada and Great Britain. Such rationing of health services will greatly impact the efficacy and efficiency of health care delivery, and frustrate the paying public, which has heightened expectations stoked by the imposition of a new health tax.

Canada and Great Britain have large budgetary expenditures for the provision of health care. Despite decades of existence, extensive organizational structure and billions of dollars of investment in their respective socialized health systems, the reviews are far from encouraging. As The Bahamas does not have the tax base or national budget to absorb the kind of skyrocketing national health deficits, the wisdom of government in trying to duplicate such a system must be questioned. In 2004, Great Britain's National Health System received a budgetary allocation of £69.7 billion pounds, which over the previous 7 years represented a doubling in government's allocation toward health care. Fifty percent of this budgetary increase was used to pay for salary increases in the British public health system, while much of the balance was used to pay for newer prescription drugs and compensatory damages arising from clinical negligence.

Despite this large budgetary allowance (nearing almost £100bn in this current year's budget, or three times what it was almost 10 years ago), Great Britain's NHS incurred consecutive health care deficits of £251million and £1.2 billion, in budget years 2004-05

and 2005-06, respectively. These deficits have raised so much concern that government has given directives to NHS administrators to slash costs wherever possible. Cost cutting measures already implemented include: mandated cuts in general practitioner referral rates to match the rates of the lowest 10%; while in East Suffolk, administrators have decided to refuse treatment to overweight Britons in need of hip and knee replacements. These measures are projected to save £44 and £47.9 million, respectively. One troubling irony lies in the fact that Britons are compelled by law to pay for a service that may be denied to them when they seek to access it.

Due to soaring costs, partly attributable to bureaucratic wastage and inefficiency, persons are finding themselves the victims of health care rationing, a policy of cutting costs by treating fewer people. A second troubling irony is that despite Britons having what is termed a "universal" and "comprehensive" health care system, the realities of this socialized model show that as billions and billions more dollars are pumped into Britain's health care budget, proportionately less and less of it is being used for needed front-line medical treatment. The result is that these same persons who are denied referral for specialty care, or denied prosthetic joint replacements when these procedures are needed, are left with two options: 1) Suffering a reduced quality of life, or perhaps death, without accessing the necessary treatment; or 2) Paying out-of-pocket costs for private health care. Hence, in this context, the terms "universal" and "comprehensive" are misnomers used to describe this health scheme, which sounds great in theory, but which fails to meet the definition of these words in practice.

The British Government has blamed the NHS deficits on poor management, and has recommended that the primary strategy to improve performance must be to increase efficiency. Our government departments in general, have not historically operated in a fashion synonymous with efficiency. The publication, The Economist, in referring to Britain's NHS deficits noted that: "stricter accounting rules exposed underlying financial problems that should have been tackled long ago". Efficiency in management is impossible without the kind of transparency and accountability afforded by proper accounting.

The complete lack of fiscal transparency within the Hospital and Health Care Facilities Licensing Board (HHCFLB) – an office established in 1997 to serve as a regulatory body responsible for overseeing the maintenance of uniform health care standards within our country's health care facilities - represents a glaring example of the lack of fiscal transparency within some government departments, as there has been a failure to present audited accounts for HHCFLB since its inception. Although HHCFLB is but a small and simple component within the bureaucracy that is MoH, it raises concerns about whether the public can expect efficiency in accounting and oversight of a far more complex proposed national health initiative. Without proper management, efficiency will be an elusive goal, resulting in millions of wasted Bahamian tax dollars.

Another shortcoming, inherent to national health care plans, is long waiting times to access treatment. Canada's system shows evidence of this challenge. A survey conducted

in October of 2003 found that the average waiting time for hospital treatment in Canada was 17.7 weeks. In 2004 in the province of Calgary, waiting times ranged from 11 weeks for cardiac surgery to 62 weeks for general surgery. Canada's Supreme Court ruled in June of 2005 that the country's waiting lists for medical treatment were "unacceptably long, causing some patients to suffer or die", paving the way for Canadians to have the freedom to access care outside the government run system. Such delays in accessing medical treatment are also related to the rationing of medical services alluded to previously. In response to this crippling problem, then Prime Minister Paul Martin vowed to spend $4 billion over 4 years to reduce waiting times in critical areas such as cancer care, joint replacement, heart surgery, diagnostic imaging and eye surgery.

Long (and slow moving) lines are nothing novel to Bahamians, in fact, this phenomenon has received notoriety in a recent pop culture song by the same title. However, there is a vast and critical difference between waiting for hours in long lines to pay a utility bill, versus waiting months to receive corrective surgery. The long lines and associated delays in accessing health services is poised to grow worse under NHI, as government predicts that utilization of public health services will increase by 20% once NHI is implemented. Such increased utilization of health services is typical of all socialized health systems throughout the world. Unless preliminary steps are taken to improve the physical capacity of our public health care facilities before the implementation of NHI, then, as many more Bahamians seek health care within our public health system, particularly PMH, the number of cases of patients having to wait in hospital corridors, in wheelchairs and on gurneys, due to a woeful lack of hospital rooms, beds or surgical theatres will only increase. At the extreme, the incidence of persons dying because they can wait no longer will also rise.

With the realities of such delays and rationing, the government cannot give assurances that patients who try to access care will not be deprived of the needed services. It is these kinds of gaps that are inherent to this model of health care, and which contribute to greater morbidity and mortality. It is our belief that a truly independent and autonomous Health Advisory Council, inclusive of lay men and women, will have to be established and responsible for hearing and investigating public complaints. This advisory council would also have the authority to recommend legal redress to all patients or their aggrieved families. This is in response to the public's misgivings about the Public Hospital Authority (PHA), with respect to doctor malpractice complaints. We assert that Bahamians must not receive taxation without representation. Furthermore, such an initiative should not be written into law without ensuring that the legislation holds government liable for the provision of quality health care.

As this is a national tax initiative, we anticipate that the government would recognize the inherent conflict of interest created by effecting this plan, while maintaining the existence of private practices within public facilities. Such a conflict exists with the PAML agreement. As the BRC has identified the shortage of hospital bed space and operating theatres for use by patients in the public wards, it will be impossible to continue the practice of having separate public and private wards when Bahamians are having equal

proportions deducted from their salaries. Such a practice is inequitable, and contradictory to the entire premise of this plan.

With BRC recommending that NHI come under the portfolio of NIB, and actuarial studies showing that NIB will become insolvent by 2029 without increasing current NIB contribution rates, or increasing the minimum age for eligibility, what assurances will government give that NHI contributions will not be used to pay NIB pension benefits, at the obvious risk and detriment of under financing the public health care system? With NIB being overstaffed by 25%, and having an exorbitant 17% expenditure on administration, it is not surprising that government would seek to streamline this department by reallocating its resources. The government's track record of overstaffing the civil service is inimical to the sustainability of this proposed plan, and leaves significant doubt about whether NHI will be immune from this type of government inefficiency.

Although Bahamians will be skeptical of government's ability to provide a caliber of health care that justifies a new tax, and regardless of the Minister of Health and BRC's warnings to the contrary, this plan will result in greater expectations of the public health care system, particularly following the gimmickry of "no more cookouts". Should the estimates for financing this plan be wrong, public outcry will be deafening. For this reason, the BDA is very concerned about the deafeningly silent approach being taken by the opposition party to this proposed health plan. For the purposes of advancing the public dialogue and our maturity as a nation, it is absolutely imperative that the official opposition make its position on this proposal known during the pre-implementation phase, rather than wait for it to possibly fail post-implementation.

According to the BRC, certain requirements must be met before launching a NHI plan:

1) Determine fees for defined health services as necessary
2) Identify areas for supplementary insurance
3) Decide the benefits to be provided

Based on the Minister's pronouncements that legislation enacting NHI is expected to be tabled this year, this suggests that we are at the pre-implementation phase of NHI. Initiation of this phase implies that the benefits of this plan have been decided, and as such the public should have already been apprised of its details. What percentage of the proposed NHI will be allocated to medical care, dental care, radiological services, laboratory services, eye care, prescription drug benefits, air ambulance transportation between the islands, and to foreign hospitals for specialized treatment not offered locally? Have such proportionate budget calculations been completed?

The list of dental services outlined in the BRC's report include: preventive care, dental fillings, extractions and dental prosthesis. This list, when compared with the array of treatment available in private practices, shows that the government plans to duplicate the very basic dental services already available in the public health system. For dentists who

have built modern practices reflecting today's standard of care, they expect a plan that allows them to continue their level of practice and to evolve as further advances dictate. It would be naïve of our association to expect our members to be satisfied with a proposal that has a regressive approach to the practice of dentistry. Despite efforts to engage the government in a dialogue to discuss the existing proposal, and contrary to misleading reports of such mutual consultation, no such meetings have occurred.

The private insurance industry has played an instrumental role in the aforementioned modernization of health care within our country. It is our contention that the existing proposal would debilitate the private insurance industry, thereby causing a significant contraction of this sector, extending to a loss in local health care professionals to foreign countries with less captive health care systems. This would inevitably result in a more expensive and inferior system than we now have. As this is an undesirable outcome, we believe that it would be preferable for the government to incorporate the private insurance sector as one of the linchpins of a revised plan, to fuel further innovation and development within our health care system.

This revised plan would involve a collaborative agreement between government, health practitioners and the insurance industry. Terms of this plan would involve government enacting legislation that would mandate the purchase of health insurance by all Bahamians, but coverage would be purchased from private insurers who already possess the administrative wherewithal, while the government retains responsibility for the construction and renovation of new and existing health care facilities.

Government would also act as a regulator, by limiting the number of insurance companies participating in this plan. The BDA is optimistic that this would facilitate mergers and acquisitions of insurance companies seeking economies of scale, which will have the beneficial effect of creating a smaller number of larger, stronger private health insurance companies. Under this agreement, insurance companies would derive greater revenue from premiums, allowing government to negotiate a favourable fixed profit margin on all health services, which would promote affordable health coverage for all Bahamians.

Under this proposal, insurance companies would only be allowed to retain a predetermined percentage of any accrued profits, a portion of which would be placed in a secured fund, as a contingency to guard against the unanticipated departure of insurance companies from the country. The companies would be subjected to annual internal audits, under penalty of law, to minimize the risk of fraud used to undermine this safeguard. Government would receive the balance of profits, and be required by law to reinvest them in the institutional upgrade and development of the system.

The upgrades would include the provision of adequate and functional infrastructural needs to support the efficient, reliable and safe delivery of health services to the Bahamian public. As dental practitioners who function in public dental facilities that do not meet basic needs, it is evident that insufficient government funds are allocated for the

provision of essential equipment and supplies. It has been suggested that the poor state of most of these facilities, PMH in particular, is partly attributable to the poor regard in which both the MoH and the general public hold dentistry. However, it gives us no solace in realizing that physicians at PMH are faced with unacceptable and severe inadequacies of their own. Such deficiencies are grossly incompatible with the government's plan to provide quality health care, and do indeed underscore the importance of increasing funding for health care in our country.

Until the Bahamian people are provided with major hospital facilities which can accommodate increased utilization, it is elementary that NHI will not succeed with existing facilities that long ago outgrew their capacity to adequately, safely and effectively meet the needs of the Bahamian public. Ironically, considering the critical nature of health care, it is quite perplexing as to why millions of dollars would be spent on the construction of a state-of-the-art national sports stadium, before overhauling our country's major public hospital, which is anything but state-of-the-art. In this regard, our country's national priorities are to be questioned, and we urge the government to follow a more ordered approach in preparing the country's infrastructural framework, before enacting NHI into law.

On the issue of increased funding, however, we do acknowledge disturbing data that reveals a weakness in the current system. Between the years 2002 and 2004 there was a decline in dental services rendered, despite increased budgetary allocation for oral health services during this period. Requisitions for the purchase of additional dental restorative materials were made, despite this decline in restorative treatment. Why were more materials being ordered for the public health clinics, when fewer patients were being seen for dental treatment?

This data emphasizes the need for greater accountability and transparency in the use of public funding, since it threatens the success of this whole plan. Whether it be at the administrative or clinical levels, penalties for fraud or theft must be severe enough to discourage practices that would increase the costs of this program. The aforementioned Health Advisory Council would hear such cases and have responsibility for making recommendation for referral to the courts, or to independently penalize offenders, resulting in their immediate suspension, dismissal, and or revocation of their professional licenses. We are sensitive to the limited financial resources available to meet our country's many health needs. Without fiscal accountability and efficiency in treatment, it becomes difficult to justify any further increases in budgetary allocations needed to realize the goal of improving the health of our nation's citizenry.

Any additional use of profits, beyond those reinvested in infrastructural improvements, would be allocated to make contributions on behalf of the indigent, and to supplement the higher costs for insuring persons above a certain age, or persons with existing illnesses. Government would further subsidize the costs of health care, by granting tax subsidies and exemptions to doctors in exchange for them providing decreased fees for the treatment of high risk patients. This would guarantee that all Bahamians have access to

health care, including those who presently do not qualify for private health insurance, and allow sharing of the costs between government and the private sector.

The BDA also believes that the public bears responsibility for the costs of health care. As this is a socialized health plan, it relies on cost sharing between Bahamians. This social interdependence is the most basic, inherent fundamental of NHI, and we must consider its implications. There is in our society, a strong correlation between the Bahamian diet, sedentary lifestyle, and the prevalence of obesity, cardiovascular disease, hypertension and diabetes mellitus. The ensuing morbidity and mortality must not be singularly viewed as an expensive burden on the immediate families, but in the context of NHI, as a variable which will significantly contribute to the overall cost of health care, borne by every tax paying Bahamian.

The BDA does not believe in a one-size-fits-all approach for the payment of NHI contributions, as there is no incentive to alter lifestyle habits that place patients at greater health risk. Without built-in incentives, cost containment is hindered. In this regard, we support the policy of rating patients on a sliding scale, relative to standardized health measurements such as blood pressure, blood glucose, blood cholesterol, percentage body fat etcetera. Annual physicals would be required to promote preventative primary care, and to determine whether any increase or decrease in these values occurred, resulting in a concomitant increase or decrease in a patient's contribution rate. A national health plan should incentivize the incorporation of diet and exercise modification to promote healthy living, and the concept of individual accountability for one's health, and the health of one's family.

Many single parents, particularly mothers, encounter great difficulty in obtaining financial assistance from delinquent fathers. As noted by the BRC, without such child support, many single parents would have difficulty making the minimal NHI contributions. Looking forward, we recognize the stress that the ever increasing preponderance of single parent families will impose on the government, which in this context, will be burdened with the responsibility of writing off the contributions of such households, and replacing them with government subsidies, or ultimately by increasing contribution rates. This begs the question: Is the government's desire to create equitable and accessible health care, in part, a policy initiative designed to address the crippling effects created by the erosion of the nuclear family within our Bahamas. We agree with the BRC's assertion that a lack of comprehensive attention and effort to combat this phenomenon will produce a negative outlook for this socialized health plan.

The BDA categorically supports the inherent right of all Bahamians to have equal access to quality health care, inclusive of catastrophic coverage that will eliminate the kind of desperation and suffering that many families without it experience. As much as we support the idea of providing equal access and affordable comprehensive health care for all, we question the feasibility and therefore the sustainability of the program in light of its grand scope.

Is the $235 million BRC estimate accurate in projecting the real costs of such a plan? By the BRC's own admission, we have not properly studied the real costs of providing health care in The Bahamas, by including those who access private health services both here and abroad. This is vital because this program will be a universal one mandating full national participation. Therefore, utilization of the public health services would very likely increase, beyond the BRC's 20% estimate. If the utilization of the program exceeds these projections, are we as a nation able to meet these cost overruns? Great Britain's NHS suffered a £50 million deficit following its first year of operation in 1948, which equates to a deficit of £1.2 billion in today's terms, when taking inflation into account. Should large scale deficits ensue, will the government be forced to dip into the national treasury to reconcile the difference, or will the Bahamian people be asked to make higher contributions? Can we afford to risk significantly increasing the country's already heavy debt burden by implementing this scheme, or to entertain the prospects of perpetual decreases in real wages at a time when the cost of living continues to increase? We must examine the implications of a proposal that may promise more than it can deliver. What starts off as a contribution of 5.3% shared by employer and employee could easily increase two to three fold, unless any program deficits are further subsidized by the public treasury.

We implore the government to create reasonable expectations within the Bahamian public, as anything less than that will likely result in deep public resentment. The premise of providing "equal access to comprehensive healthcare" demands explanation as the BRC's report explicitly states that "under the NHI system, residents would have access to the public and private healthcare systems,…**referrals abroad as allowed by the regulations and guidelines**…and have the **option of purchasing services which exceed or are not covered by the NHI system**."

By this information alone, it must be acknowledged that this plan is not "comprehensive", and still leaves allowances that certain treatment and services will be beyond the scope of this plan. Being fair, it is unreasonable to expect such a plan to provide unlimited health care services. However, it cannot be claimed that this plan will do away with the need for cookouts as a means of raising funds to pay for health care, unless they are able to supplement their NHI coverage with secondary coverage purchased from private insurers.

Recognizing that the same segment of the population that NHI is designed to help, would likely find difficulty affording such secondary coverage, it should be known exactly what services would lack coverage, so that an alternative supplementary plan could be devised and the cost calculated. Only then, can the Bahamian public know what the true cost of comprehensive health care would be, following the implementation of NHI. For purposes of comparing health care expenditures between countries, Great Britain's 2006-2007 budget is £96 billion, which equates to £1583 or $2995 spent per capita, while Canada's 2005 health care budget was $142 billion or $4,411 spent per capita. Both the United Kingdom's and Canada's socialized health care systems are unable to meet the demand for their health services, despite enormous budgets, that are four and almost six times

larger, respectively, per capita than the $775 that BRC endorses as being adequate enough to provide comprehensive health care for the Bahamian people. With such a vast difference between what the BRC proposes such a plan will cost, and what established systems spend, what kinds of caps or limits will the government impose on Bahamians needing catastrophic or critical care? A NHI representative has confirmed that 70% of medical services will be covered under NHI. What are the services that fall in the category of the 30% that won't be covered. Bahamians deserve to know exactly what health benefits NHI will guarantee, before they are forced to pay for it, and not after.

Can NHI be expected to provide comprehensive prescription drug benefits to all Bahamians? We know that the cost of Canada's prescription drug benefit is now so high - $24.8 billion per year, up 11% from a year ago - that it exceeds the cost of physician salaries in that country. When one calculates the per capita drug costs under Canada's public health system, it works out to $749 per Canadian, or 17% of the total $4,411 that Canada spent on health care per capita in 2005. When one compares the projected $775 per capita expenditure on health care for Bahamians under NHI, it is just $26 more than what Canada spends on prescription drugs alone, never mind actual medical services. The cost of these drugs will only continue to increase as pharmaceutical companies continue to pump hundreds of millions of dollars into research and development programs. This single variable stands to severely affect the proposed cost of the NHI program, and will certainly compel the government to significantly limit the size of its approved drug formulary. What, therefore, will be the composition of this approved drug list, and what medications will Bahamians have to pay separately for, which will add to the costs of this plan? Again, the public must be given realistic expectations for a plan that has the very real probability of reaching a disproportionate ratio between demand and expenditure.

In conclusion, some form of medical insurance coverage is needed to provide a safety net for the Bahamian people, all of whom deserve access to quality health care. Bahamians will be justified in expecting an improved standard of health care, beyond what is presently offered in the public health system, from any plan that mandates their economic participation. This is without question. The BDA feels strongly that this plan, as it is presently proposed, has too many weaknesses, limitations and unanswered questions that must be addressed before it could be implemented with any hope of being sustainable or successful. Therefore, it is our hope that government would advance a revised plan, giving greater consideration to its scope and form, so that the many questions and concerns discussed do not go unchecked, resulting in a failed national experiment, with far reaching negative consequences.