

GOVERNMENT OF ST. KITTS AND NEVIS



**GREEN PAPER
ON
UNIVERSAL HEALTH CARE
FOR THE
FEDERATION OF
ST. KITTS AND NEVIS**

October 2018

THE NATIONAL CONTEXT

As part of the Government of St. Kitts and Nevis' (SKN) 'Fresh Start and Prosperity Agenda', both the Prime Minister and the Minister of Health in their 2016 Budget Addresses (December 2015) outlined several ongoing programs for improving access to care for all and overall functioning of the health system.

Additionally, on page eighteen (18) of the Team Unity Manifesto the administration recorded their commitment to "within its first term in office, commission a comprehensive national health insurance plan for all citizens of St. Kitts and Nevis."

Renewed policy attention to Universal Health Care and a National Health Insurance System (NHIS) is being driven by ongoing concerns and challenges related to the burden of diseases, the demand for, delivery and financing of an efficient health care services with the need to 'be more sustainable'; 'provide barrier-free access' and 'improve financial protection.'¹

These concerns and challenges include, but are not limited to:

- Gaps in accessing care especially by those without private insurance who have to make high out of pocket payments;
- Gaps in availability of tertiary care²;
- Challenges to sustainability of health financing due to the expenses related to the managements of chronic diseases, addiction and injuries;
- Challenges with self-responsibility and cost-sharing for one's health;
- Challenges with maximizing service delivery capacity and quality of the public and private sectors;
- Challenges with transforming the health system to an evidence-driven, Information Technology-guided, patient-centred future.

The Federation of St. Kitts and Nevis already has several pre-requisites in place for action on a viable, sustainable National Health Insurance System (NHIS). These include, but are not limited to:

- a) New policy drive for a 'fresh start' and 'universal health care
- b) Positive economic growth prospects
- c) Contributory employer-employee social security system covering all employees including the self employed
- d) Informal Public-private-overseas network of health providers
- e) Ongoing initiatives for enhancing availability and quality of care such as the introduction of tertiary care services such as oncology and the Health Management Information Systems.

¹ Review of reports on the health system and health financing eg. OECS, 1999; Gov't of St Kitts-Nevis National Strategic Health Plan, 2008—2012; Abt Associates, 2013; PAHO-HEU, 2015).

² Tertiary Care is defined as care provided by a specialist

UNIVERSAL HEALTH CARE³

The World Health Organization (WHO) defines Universal Health Care as “*access to all people to the health services they need (prevention, promotion, treatment, rehabilitation and palliative care) without the risk of financial hardship when paying for them.*”

For this to occur, the following are required:

- a) An efficient health system that provides the entire population with access to good quality services, health workers, medicines and technologies
- b) A financing system that protects people from financial hardships and impoverishment from health care costs

The benefits to Universal Health Care:

- a) Access to health services ensures healthier people
- b) Financial risk protection prevents people from being pushed into poverty

Therefore Universal Health Coverage is a critical component of sustainable development and poverty reduction and a key element to reducing social inequalities.

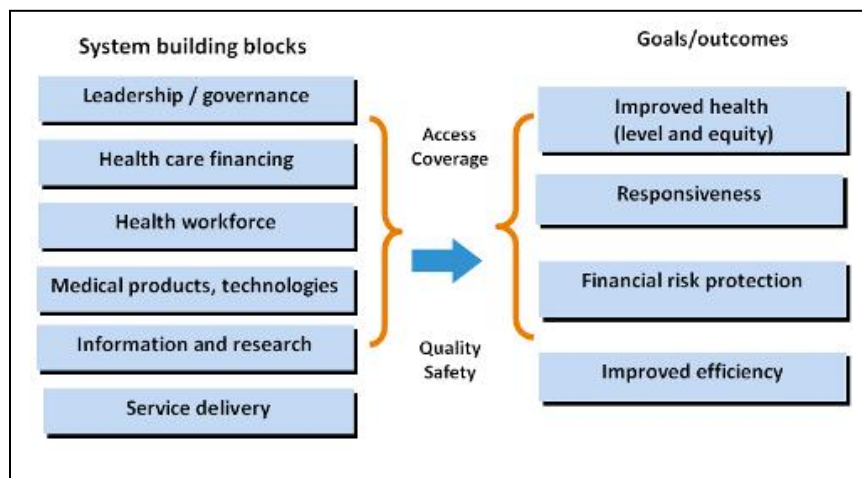
Factors that are needed to achieve Universal Health Care:

- a) A **strong, efficient, well run health system** that meets priority health needs through people centered integrated care by:
 - i. Informing and encouraging people to stay healthy and prevent illness
 - ii. Detecting health conditions early
 - iii. Having the capacity to treat disease
 - iv. Helping patients with rehabilitation
 - v. Ensuring sensitive palliative care where needed
- b) **Affordability** – a system for financing health services so people do not suffer financial hardships when using them
- c) **Availability of essential medicines and technologies** to diagnose and treat medical problems
- d) A sufficient capacity of **well trained, motivated health workers** to provide the services to meet patients’ needs based on the best available evidence
- e) Actions to **address social determinants of health** such as education, living conditions and household income which affect people’s health and their access to services.

³ World Health Organization (WHO)

What Universal Health Care is not!⁴

- i. Universal Health Care **DOES NOT MEAN** free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis
- ii. Universal Health Care **IS NOT JUST** health financing. It encompasses all components of the health system:
 - a. Health service delivery systems
 - b. The health workforce
 - c. Health facilities
 - d. Communication networks
 - e. Health technologies
 - f. Information Systems
 - g. Quality Assurance Mechanisms
 - h. Governance
 - i. Legislation
- iii. Universal Health Care **IS NOT ONLY** about ensuring a minimum package of health services but also about ensuring progressive expansion of coverage of health services and financial protection as more resources become available
- iv. Universal Health Care **IS NOT ONLY** about individual treatment services but also provides population wide services such as:
 - a. Health Promotion Example - public health campaigns
 - b. Environmental Health Example - adding fluoride to water
 - c. Vector Control Example - controlling mosquito breeding grounds
 - d. Port Health Example - inspection of goods and people entering a territory
- v. Universal Health Care **IS COMPRISED OF MUCH MORE** than just health; taking steps towards Universal Health Care means taking steps towards equity, development priorities and social inclusion and cohesion



⁴ World Health Organization (WHO)

**OPTIONS FOR ESTABLISHING UNIVERSAL HEALTH CARE FOR THE
FEDERATION OF ST. KITTS AND NEVIS**

Area for Consideration	The Situation	Options
<p>Single Pooling of Resources</p>	<p>According to the 2011 National Health Accounts for the Federation, 55% of total health expenditure is paid for by households. The recommended portion should be no more than 20%.</p> <p>This situation is indicative of inadequate pooling of resources to cover medical expenses for the greatest portion of the population.</p> <p>Recommendation: The establishment of a National Health Insurance System</p>	<p>Option A: The establishment of a statutory body with responsibility for the collection of an earmarked amount of funds from a source to be determined that would be used to provide medical coverage for the applicable population. Example: Turks and Caicos Islands</p> <p><u>Advantages:</u></p> <ul style="list-style-type: none"> - Provides employment opportunities - Establishes a designated infrastructure to manage this new initiative <p><u>Disadvantage:</u></p> <ul style="list-style-type: none"> - A costly endeavor to establish and staff a new entity <p>Option B: The expansion of the Social Security Board to take responsibility for the collection of an earmarked amount of funds from a source to be determined that would be used to provide medical coverage for the applicable population. Example: British Virgin Islands</p> <p><u>Advantages:</u></p> <ul style="list-style-type: none"> - Public trust with the collection of contributions and the payment of benefits - Has an experienced staff compliment to perform many of the functions required for National Health Insurance. <p><u>Disadvantage:</u></p> <ul style="list-style-type: none"> - Limited infrastructure and experience with medical provider networks and claims processing

Area for Consideration	The Situation	Options
Sources of Financing	At present, there is no singular tax that is collected to off-set the cost of health care in the Federation.	<p>Option A: Introduction of a contribution to be dedicated to financing the National Health Insurance System</p> <p><u>Examples:</u></p> <ul style="list-style-type: none"> - Direct salary deduction from each employed person - Matching contribution from each employer on behalf of all employed persons <p>Option B: Re-direct a portion of existing taxes to finance the coverage</p> <p><u>Examples:</u></p> <ul style="list-style-type: none"> - Transfer of the portion of the 1% Employment Injury used to cover medical expenses as paid for by employers on behalf of each employee. - Transfer of a portion of the Housing and Social Development Levy - Transfer of a portion of the funds used by Government to cover its employees' medical insurance <p>Option C: A combination of both options</p> <p><u>Examples:</u></p> <ul style="list-style-type: none"> - Transfer of the full annual budgetary allocation provided to the Department of Social Services to aid in medical assistance - Direct salary deduction from each employed person - Matching contribution from each employer on behalf of all employed persons <p><u>Considerations:</u></p> <ul style="list-style-type: none"> - What would be the impact of diverting funds from existing taxes be on the Government and Social Security Board's ability to meet its other obligations to the population?

Area for Consideration	The Situation	Options
Contribution Threshold	For all other similar taxes namely Social Security and Housing and Social Development Levy, there is a threshold (minimum and maximum) for deductions.	<p>Option A: Establishment of a contribution threshold that excludes persons earning less than minimum wage and a maximum to be determined following examination of data.</p> <p><u>Consideration:</u> The cost of covering this population will be borne either by the State, who presently covers a large portion of the medical cost for that population or the remaining of the employed population.</p> <p>Option B: No threshold shall be established therefore making all wages subject to having the agreed upon rate of contribution being deducted to finance the coverage.</p> <p><u>Consideration:</u> Increased deduction by those earning minimum wage could have unintended consequences for their ability to cover living expenses.</p>
Who shall be covered?	Noting the challenges with residency requirements, a different approach would have to apply for NHIS.	Coverage is extended to all qualified persons who pay the stated contributions or on their behalf contributions are paid.
Coverage Approach		<p>Option A: Full coverage to all applicable populations upon launch of the Programme</p> <p><u>Considerations:</u></p> <ul style="list-style-type: none"> - The role of the state in providing additional financing support to ensure the financial sustainability of the Fund. <p>Option B: Phased approach whereby different populations are added to the Programme following the attainment of key performance indicators.</p> <p><u>Consideration:</u></p> <ul style="list-style-type: none"> - A population that is contributing but not receiving access to services.

Area for Consideration	The Situation	Options
<p>Categories of Covered Populations</p>	<p>At present, health insurance coverage is left to an individual to opt to have or may only have as a result of his/her employment.</p> <p>The employed population that contributes to Social Security on a monthly basis is quoted as 29,195 as of July 2017.</p> <p>Of this population, it is estimated that 30% is already covered by insurance either through their employer or privately. A majority of these persons, roughly 20% are employed by the Government.</p>	<p>Employed persons: Citizens, nationals and legal residents as duly registered with the Social Security Board</p> <p>Self Employed Persons: Citizens, nationals and legal residents as duly registered with the Social Security Board at the same rate as an employed person.</p> <p>Voluntary Contributors: This allows for individuals to make voluntary contributions to receive coverage. For example, the citizens residing overseas.</p> <p>Unemployed senior citizens over the age of 62 years: Once a citizen, national or legal resident has attained the age of 62 and continues to be gainfully employed then the NHI deduction will be made from their salary/wages.</p> <p>Children of nationals, citizens, and legal residents up to the age of 25 if enrolled full time at an institution of higher learning. The institution of higher learning shall be duly registered with an accredited educational authority. The student must be enrolled on a full-time basis and the contribution shall be made payable by the Government of St. Kitts and Nevis.</p> <p>Indigent/Poor and Vulnerable: As certified by the Department of Social Services and Community Development. Their contribution shall be payable by the Government of St. Kitts and Nevis. This classification includes, but is not limited to:</p> <ul style="list-style-type: none"> - Disabled persons - Prisoners - Wards of the State <p>If Prisoners earns wages from work performed then a deduction shall be made from those wages.</p> <p>Unemployed: The unemployed shall be covered for a specific period with key responsibilities. These include registration with the Department of Labour and actively seeking employment as certified by the Department of Labour.</p>

Area for Consideration	The Situation	Recommendation
<p>Categories of Restrictions</p>		<p><u>Student Population:</u></p> <ul style="list-style-type: none"> - Coverage ONLY for local care within the island. - Enrollment shall be certified through the submission of an annual letter of enrollment. <p>Additional Considerations:</p> <ul style="list-style-type: none"> - The International University student population – coverage or a mandate to attain private insurance? - Dependents of legal residents – coverage paid for by the state or the legal resident pays for their dependents? <p><u>Work Permit Holders:</u></p> <ul style="list-style-type: none"> - No coverage shall be provided within the first year. If the work permit is extended extends beyond one year they can begin contributing in month nine so as to start receiving benefit at the end of the year. <p style="text-align: center;">ALTERNATELY</p> <ul style="list-style-type: none"> - Coverage extended to them upon start of contribution so as to build the pool of contributors
<p>Waiting Period</p>	<p>Recognizing that: There is at present no designated pool of funds to immediately finance the introduction of National Health Insurance.</p> <p>The desire of the Team Unity Administration to cover a majority of the applicable beneficiaries at the time of introduction</p> <p>The expectation of the population to receive a comprehensive benefit package as a result of direct contribution for health care.</p>	<p>Option A: Coverage shall commence three (3) months after the payment of the first contribution on behalf of an applicable individual. During the three (3) month waiting period individuals will be responsible for all medical related expenses. No reimbursement of medical expenses sought during the waiting period shall be approved.</p> <p><u>Consideration:</u> This approach allows for the Fund to accumulate prior to having to settle expenses.</p> <p>Option B: No waiting period introduced. This would mean that that coverage commences with the first contribution.</p> <p><u>Consideration:</u> A start up fund would need to be provided by the State</p>

Area for Consideration	The Situation	Recommendation
<p>What does it cover?</p>	<p>Recognizing that the present gap in service delivery for the Federation is at the tertiary level – specialist care – it would be necessary for clients of the NHIS to seek treatment overseas.</p> <p>Medical expenses could include the following:</p> <ul style="list-style-type: none"> - Charges for services by professionals and institutions - Travel expenses - The cost associated with a person accompanying (travel, accommodations, subsistence) 	<p>Option A: Medical expenses related to the patient ONLY. Coverage shall not include the cost of an accompanying adult.</p> <p>Option B: Medical expenses related to the patient and where it is medically necessary for someone to accompany the patient, assistance will be provided for an accompanying adult to travel with the patient. Assistance shall cover travel, accommodation and subsistence.</p>
<p>Benefit Package</p>	<p>At present, a comprehensive network of services is offered by the public sector. The intention of the NHIS is to offer at least what was offered in the public sector with additions based on the disease burden of the Federation.</p> <p>According to a study undertaken on the burden of disease by the UWI – HEU consultant team, the following was revealed.</p> <p>Child Health (0-5 years):</p> <ul style="list-style-type: none"> - Low birth weight - Respiratory infections and diarrheal diseases are the leading causes of death <p>Children Adolescent Health (5 – 19 years):</p> <ul style="list-style-type: none"> - Anemia is estimated at 37% among 6-9 year olds - Overweight and obese: 13 – 15-32.5% over, 14.4% obese - Substance Abuse - Physical Violence - Sexual Assault 	<p><u>Primary care:</u></p> <ul style="list-style-type: none"> - Nutrition - Maternal (Obstetrics) and child health - Immunization <p><u>Family Planning:</u></p> <ul style="list-style-type: none"> - Contraceptives - Testing - Counseling for achieving pregnancy and loss of pregnancy - Sterilization and tubal ligations <p><u>Preventative care:</u></p> <ul style="list-style-type: none"> - Testing - Screenings: Mammogram, Colonoscopy - Counseling - Immunization <p>Specialist visits Casualty and Emergency Room Care Surgery and Intensive Care Hospital Room and Board</p> <p><u>Diagnostic procedures:</u></p> <ul style="list-style-type: none"> - X-Ray - Biopsy - Ultra Sound - CT Scan - MRI - Prostate specific antigen

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<p>Benefit Package</p>	<p>Adults (20+):</p> <ul style="list-style-type: none"> - One in every five adults live with diabetes. That is 20% of the population - Other common diagnosis: Hypertension Cancer of the breast, cervix and prostate <p>Mental Health:</p> <ul style="list-style-type: none"> - Six common mental health disorders for the period 2011-2016: Schizophrenia Bipolar disease Schizoaffective disorder Cannabis induced psychosis Substance dependency <p>Dental Health:</p> <ul style="list-style-type: none"> - Dental caries is a main challenge to oral health in children - Just over 60% of students consume sugar-sweetened carbonated beverages one or twice per day <p>Vision Health:</p> <ul style="list-style-type: none"> - Complications from Diabetes <p>Rehabilitation Services:</p> <ul style="list-style-type: none"> - Amputations as a result of diabetes complication - Physical violence – gun shot and motor vehicle accidents 	<p>Pharmaceutical services: in accordance with the National Drug Formulary</p> <p><u>Mental Health Services:</u></p> <ul style="list-style-type: none"> - Occupational Therapy - Hospitalizations - Medication - Counseling - Medical Treatments <p><u>Dental Care:</u></p> <ul style="list-style-type: none"> - Annual cleanings - Filings - Extractions <p><u>Vision Care:</u></p> <ul style="list-style-type: none"> - Annual examination - Glasses or contact lenses - Surgery – where medically necessary <p><u>Rehabilitation Services:</u></p> <ul style="list-style-type: none"> - Physical therapy - Occupational therapy - Speech and language therapy - Cognitive therapy <p>Psychological services</p> <p><u>Overseas care:</u></p> <ul style="list-style-type: none"> - If the specialist is not available locally or available to visit the Federation - Transportation for overseas care <p><u>Considerations:</u></p> <ul style="list-style-type: none"> - Establishing clear utilization numbers for each service being provided - Adjusting the benefit packages based on the illness profile – for example more CT Scans for cancer patients etc - Phased approach to the introduction of services to the benefit package

Area for Consideration	The Situation	Recommendation
Exclusions	<p>It is necessary to establish exclusions to the range of benefits and services covered by the NHIS.</p> <p>This safeguards the NHIS against the expectations of the client base while at the same time</p>	<p>Consultations and treatment for infertility including in-vitro fertilization, artificial insemination and sex change procedures</p> <p>Weight loss procedures and treatments unless medically necessary</p> <p>Cosmetic procedures (medical and dental) unless medically required and pre-approved</p> <p>Adult orthodontics, unless medically necessary</p> <p>Podiatry unless medically necessary</p> <p>Self-referred second opinion by overseas providers</p> <p>Short term nursing home/skilled nursing home stay unless medically necessary and pre-approved</p> <p>Prosthetics devices</p> <p>Counseling and therapy for marital and family difficulties</p> <p>Mortal remains repatriation – exceptions only in cases where off-island care of the deceased beneficiary was preapproved by the Medical Review Committee prior to death</p> <p>Treatment or participation in any health science deemed to be experimental.</p> <p>Experimental for this policy refers to treatments, medicines or other procedures which are a part of a research programme and have not been approved by the relevant medical board and/or accreditation authority.</p> <p>Therapeutic, alternative or preventative health care practices such as homeopathy, chiropractic and herbal medicine that do not follow generally accepted medical guidelines or standards and may not have a scientific explanation for their effectiveness.</p>

Area for Consideration	The Situation	Recommendation
Maximum Benefit	It is imperative to establish the lifetime limit for coverage by the NHIS. This allows for the expectations of the beneficiary population to be managed and scope for service delivery by private insurance companies.	<p>Option A: Lifetime limit per insured person to be determined following an Actuarial Review. <u>Example:</u> One million dollars per person.</p> <p>Option B: Limit that is renewable per individual after a set number of years. <u>Example:</u> \$750,000 renewable every three years - Government health insurance policy</p>
Co-payments	This is defined as the amount paid by a patient for receipt of medical care and services.	<p><u>In – Network:</u></p> <ul style="list-style-type: none"> • Public Providers – Health Centers - NHI 100%, Individual 0% • Public Providers – JNF and Alexander – NHI 95%, Individual 5% • Private Providers – NHI 90%, Individual 10% • Overseas in network – NHI 80%, Individual 20% <p><u>Out of Network:</u></p> <ul style="list-style-type: none"> • Private Sector – NHI – 80%, Individual 20% • Overseas – NHI – 60%, Individual - 40% only in emergency and in cases of pre-approval. <p>Considerations:</p> <ul style="list-style-type: none"> - The establishment of an agreed upon fee structure that is accessible and known by all parties
Balance Billing	<p>This is used to define the practice of a healthcare provider billing a patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge.</p> <p>The intention is to limit out of pocket expenses for the beneficiaries</p>	<p>Option A: NHIS to not allow for balance billing through the establishment of preferred provider classifications and active negotiations with the medical practitioners to ensure that the fee structure is competitive.</p> <p>Option B: Allow balance billing but set a ceiling. For example, no more than 5% of the rate covered by insurance.</p> <p>Option C: Permit reimbursements of the balance to service providers based on standard of care provided.</p>

Area for Consideration	The Situation	Recommendation
GOVERNANCE AND ADMINISTRATION		
Governance Matters	Based on the type of institution to be established – new statutory entity or an expansion and diversification to Social Security Board – considerations would have to be made to the Board of Directors.	<p>Option A: The creation of a new Board of Director to govern the affairs of the statutory corporation.</p> <p>Option B: Expansion and diversification of the membership of the existing Social Security Board.</p>
Staffing		<p>Option A: The Statutory entity will be staffed in a phased approach that utilizes support from existing entities.</p> <p><u>Considerations:</u></p> <ul style="list-style-type: none"> - By the start of 2019, the key managerial structure will be in place - Support shall be provided by the Government in the area of legal advice and representation - Support shall be provided by Social Security to collect the contributions, ensure compliance and access to databases of contributing populations. - Competitive tender amongst the private insurance companies to utilize provider networks and claims processing software. - Administrative departments to be deployed: <ul style="list-style-type: none"> - Finance, Investment and Internal Audit - Compliance – collections and audit units - Registration - Benefits and Records - Clinical Services - Case Management Services - Human Resources - Research - Communications - Information Technology <p>Option B: Expanding and diversifying the staff of the Social Security Board in the following areas:</p> <ul style="list-style-type: none"> - Clinical Services - Case Management Services - Compliance: Audit of service providers - Research

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Medical Review, Appeals and Complaints Mechanisms	<p>There should be legislated the capacity for registered persons to appeal decisions as to the quality of health care provided, for service providers to appeal their rejection or dismissal and for general complaints about service providers and beneficiaries.</p>	<p>1. Medical Review Committee: Responsible for reviewing request for specialist care and making recommendations to the NHIS about facilitating such requests.</p> <p>2. Complaints Committee: Assembled to address all complaints against service providers and beneficiaries.</p> <p>3. Appeals Committee: For all matters of appeal – medical, service provider etc.</p>
Administrative Matters: IT Requirements	<p>For there to be an effective NHIS, the information processing framework is to be made up of the following components:</p> <ul style="list-style-type: none"> - <u>Registration:</u> employers and contributing populations - <u>Contributions:</u> payments made by and on behalf of the applicable contributing populations - <u>Health Information System:</u> medical and claims history per individual, service provider, medical condition, etc. - <u>Claims Processing:</u> ensuring that minimum care guidelines were followed prior to approval of payment to service providers (local and overseas) - <u>Accounting:</u> receipts and expenditures - <u>Individual Case Management System:</u> follow-up of the care provided to ensure that the expected results are attained. 	<p>Option A – New Statutory Entity: The following systems will be developed for use by the new statutory entity:</p> <ul style="list-style-type: none"> - <u>Registration:</u> The database shall be populated with information from Social Security (employee and employer information), Immigration (migrants, work permit holders, economic citizens) and the Civil Registry (birth and death). - <u>Accounting:</u> This is to be sourced for the NHIS to manage cash inflows and outflows. - <u>Individual Case Management:</u> management of follow-up care. <p>Agreements will be entered into with the following entities to provide support for the first three – five years of implementation</p> <ul style="list-style-type: none"> - <u>Social Security Board:</u> Contributions - <u>Ministry of Health:</u> Health Information System - <u>Private Insurance Companies:</u> medical claims processing <p>Option B – Social Security Board Utilization and expansion of the systems already being utilized by the Social Security Board:</p> <ul style="list-style-type: none"> - Registration, Contributions and Accounting <p>Establishment of new systems either through construction or agreements:</p> <ul style="list-style-type: none"> - Establish Individual Case management and medical claims processing - Agreement with Ministry of Health for Health Information System

Area for Consideration	The Situation	Recommendation
OPERATIONAL MATTERS		
The NHIS Card	<p>At present, each applicable person in the Federation has a Social Security and a National Identification Card.</p> <p>The Social Security Card is not machine readable but the National Identification Card is.</p> <p>Additionally, the Health MIS card is presently machine readable.</p>	<p>A machine-readable card that once swiped provides access to the following information:</p> <ul style="list-style-type: none"> - Bio Data: name, DOB, NHIS number - Eligibility classification - Medical Records by classification <p>Options:</p> <p>1. <u>National Identification Card:</u> Using the machine-readable capacity of the card, the National Health Insurance information can be programmed onto that card.</p> <p>2. <u>Health MIS Card:</u> Change the title of the card to the National Health Insurance Card so as to expand utilization.</p>
Cases of patients going beyond annual or lifetime limits	<p>Owing to the existing health profile of the Federation which shows that some chronic care diseases can easily exhaust the lifetime limit it is necessary to propose options for the beneficiary as well as the NHIS.</p>	<p><u>Reinsurance:</u> This is a practice in which insurers transfer portions of portfolios to other parties in order to reduce their exposure to claims. It can be likened to insurance for insurance companies. An insurance company can reduce its risks from policies it has underwritten by spreading some of that risk to other insurers. Reinsurance enables insurers to spread risk and function more effectively. They can take on more business without substantially increasing their exposure or obligations.</p> <p><u>Private Insurance:</u></p> <p>There is also the option for persons with pre-existing conditions, exposure to and family history of certain medical conditions to take out additional medical insurance to cover additional expenses related to health services that may exceed the benefit limit of the National Health Insurance System.</p>
Access to Care: Order of service providers	<p>It is critical that the NHIS establishes and publicizes the order of service providers. This would ensure that</p>	<p>Service providers will be sought in the following order:</p> <ul style="list-style-type: none"> • <u>Local:</u> full time or visiting status with the Federation • <u>Networked Provider</u> • <u>Out of network provider</u> with pre-authorization

Area for Consideration	The Situation	Recommendation
<p>Access to care: Off Island</p>	<p>Access to overseas care which would be most expensive category of care must be closely and carefully managed.</p> <p>Pre-authorizations refers to situations whereby though the medical treatment is covered by the benefit package access has another layer of process.</p>	<p>Access to specialized care requires a gate keeper system where the client is required to see a general practitioner but not too rigid so as to restrict specialist care.</p> <p>The specifics shall be determined following in-depth consultations with the medical and allied health professionals.</p> <p>The Process: Physician submits the formal application for pre-authorization:</p> <ul style="list-style-type: none"> • Bio data on the client • Medical History complete with labs and any other diagnostic test <p>In cases of emergencies, the Medical Director approves the request for services.</p> <p>The Medical Review Committee meets to review all non-emergent cases.</p> <p>Final decision is made by the Medical Director</p> <p>Decision is forwarded to the Clinical Services Department for outreach to service providers in the network and to case management department for notification of client</p> <p>Letter of guarantee/ Pre-Authorization prepared.</p> <hr/> <p><u>Case Classifications:</u></p> <ul style="list-style-type: none"> • Emergent – within 24 hours of receipt Also based on bed availability throughout the network – most frequent reason for delays • Urgent – within 72 hours • Routine – within 14 working days <p>Classification identified by the physician and confirmed by the Medical Review Board</p>

Area for Consideration	The Situation	Recommendation
After Care	To attain the full results of care following an intervention, it is imperative that follow-up be undertaken by primary physicians and the NHIS.	<p>After care including from overseas referrals should be based on a cooperative relationship with primary physicians.</p> <p>The process is managed by the Case Manager upon return to the territory.</p> <p>It is recommended that the clear guidelines be established for the timeframe and reporting requirements for follow-up by case managers.</p> <p>The results are to be reported on the medium-term results of the intervention and treatment</p> <p>If the specialist requires to see the patient again, the Medical Review Board determines if that is necessary as the care may be provided locally</p>
SERVICE PROVIDERS AND MEDICAL NETWORK		
Registration of Service Providers	To ensure access to quality service providers the NHIS must establish guidelines for interested parties to serve as approved service providers.	<p>Revisions to the Medical Act that would expand the requirements for registration of medical professionals to include the following:</p> <ul style="list-style-type: none"> - Indemnity Insurance - Mal practice insurance is presented - Mandates to attend continuing education session
Service Providers: medical teams	There is need for specific operational determinations for the management of service providers – local and overseas	<p>Produce care guidelines to go alongside the services. <i>Thorough and consistent consultations should be had prior to a final determination of the Clinical Care Guidelines</i></p> <p>Establish and maintain standards and accreditation for health care providers and institutions. <i>This is to be facilitated by the Ministry of Health as they are responsible for standards in the health sector and regulations.</i></p> <p>Have contracts with ALL Service providers that would outline the payment schedule and rules and guidelines which includes, but is not limited to payment schedule and frequency.</p> <p>Establish the scope of practice for all service providers before billing. This may require some practitioners to be grandfathered into the system. <i>Assistance will be sought from the associations and councils as to the way forward.</i></p>

Area for Consideration	The Situation	Recommendation
Service Providers: medical teams	There is need for specific operational determinations for the management of service providers – local and overseas	Allow for physicians who practice in both spheres (public and private) to register under two profiles to aid in billing and tracking of services provided
Service Providers: Pharmacy and druggist	There is need for specific operational determinations for the management of pharmacies and druggist.	<p>Establish a National Drug Formulary in consultation with medical practitioners prior to implementation.</p> <p>Establish clear processes for revisions.</p> <p>Unit cost and quantity prescribed for each drug is to be recorded in the system</p>
Incentive Packages	<p>The focus of the NHIS should be greater than disease treatment to being disease prevention.</p> <p>To facilitate this, incentives could be provided to individuals and service providers to ensure that more persons remain healthy and access care at the primary level.</p>	<p>It is being proposed that the following be considered when creating the incentives for the NHIS:</p> <ul style="list-style-type: none"> - Incentivize treatment based on health information in the areas of national priority. For example, NCD, Chronic illnesses, HIV/AIDS etc. - Incentivize local capacity development. For example, the establishment of a repayment process for the introduction of medical innovation that rebounds to health savings and increased care and the expansion of the visiting specialist pool to provide more services on island. - Provide incentives for people to use the system sensibly and stay healthy.
HEALTH INFORMATION MANAGEMENT SYSTEM		
The Health Management System: Coding	Medical coding is required to ensure proper record keeping, billing and reporting.	Establish coding requirements based on industry standards and train physicians and other staff.
The Health Management System: Set Up	At present, the Ministry of Health with assistance from the Taiwanese Government has begun the roll out of the Health Management Information System. One of the key functions of this system is to provide practitioners with access to key medical information on an individual when they present to them for the first time or as a repeat client.	<p>It is being proposed that the Health Information Management System be designated as the National Medical Records depository. With this designation each registrant and immigrant would be required to submit medical records as to their health or submit to a physical examination so as to provide that information.</p> <p>The medical history of the individual shall be accessible to medical practitioners with the appropriate restrictions. To this, each physician adds notes on clinical interactions with the patient.</p>

Area for Consideration	The Situation	Recommendation
<p>The Health Management System:</p> <p>Set Up</p>		<p>For the immigrant population, management of their medical records shall be through the immigration process. At entry they are required to submit a Medical Certificate. This certificate is to be verified by a local practitioner following examination within a stipulated period after entry into the Federation. That information is then entered into the HMIS.</p>
<p>The Health Management System:</p> <p>Confidentiality</p>	<p>Protection of an individual's medical records is critical to public satisfaction with the system.</p> <p>To safeguard individual medical records, the following shall be instituted:</p>	<p>Only with the swipe of the card can the medical records of the individual be accessed. That is, no access will be provided with the simple input of the NHIS number. This is to ensure that practitioners are only accessing medical records when offering service to a client.</p> <p>Consideration would have to be given to a maximum time window for access to the medical files of the patient. In reality there would be little time for a doctor to enter all medical information within the same day or work hour. As such, as the card requires to be swiped, the file should be accessible for a window of time if the physician's office does not have the necessary clerical support to enter the medical history while the physician sees the next client.</p> <p>Different levels of access will be provided to practitioners. For example, the specialist and general practitioner shall be able to see all medical notes. Once referred for allied services (counseling, therapy etc) the general practitioner shall be able to see those medical records. If not referred then the client would need to provide written consent to the NHIS for the general practitioner to gain access. The allied health provider shall be able to see only information related to the execution of their duties – a summary for referral purposes. The client would have to give written consent for any other information to be released. Pharmacist and druggist shall only be able to see the drugs prescribed not the medical situation that gave rise to the prescription of the drug.</p> <p>Final decisions will be made following in depth discussions with the medical and dental association, nurses council and allied health professionals.</p>

Area for Consideration	The Situation	Recommendation
THE HEALTH SYSTEM		
Strengthening of the Ministry of Health	<p>Our current health system is governed by various pieces of legislation. The Public Health Act No. 22 of 1969 gives the Ministry of Health, under the supervision of the Minister of Health the authority to perform the following duties:</p> <p>Assessment (Service Delivery): monitor health, diagnose and investigate</p> <p>Policy Development: inform, educate, empower; mobilize community partnerships; develop policies</p> <p>Assurance (Regulate): enforce laws; link to/provide care; assure competent workforce; evaluate.</p>	<p>Introduction of a Monitoring and Evaluation Unit within the Ministry of Health that is responsible for quality assurance within the health system.</p> <p>Proposed responsibilities:</p> <ul style="list-style-type: none"> - Aid in the licensing of medical service providers: labs, pharmacies, clinics - Conduct visits to service providers to ensure compliance with sector standards and to enforce the laws
Registration and regulation of medical and clinical care providers	<p>At present, only the following classification of medical practitioners are required to register and become licensed to practice in the Federation:</p> <ul style="list-style-type: none"> - Medical Practitioners - Chemist and Druggist - Opticians - Dentist - Podiatrist - Chiropractors and chiropodist 	<p>Revisions to the Medical Act to legislate the registration and licensing of other clinical care providers such as:</p> <ul style="list-style-type: none"> - Psychologist - Social Workers - Counselors - Therapist - Nutritionist <p>Provisions should also be made for the Medical and Dental Board to oversee and regulate these allied health professions.</p>
Registration and regulation of medical service institutions	<p>At present, to function as a business rendering medically related services, you only need to acquire a business license.</p> <p>In an effort to attain quality assurance standards for spaces that provide medical services, it is imperative that additional licensing and regulatory frameworks be established.</p>	<p>Revisions to the Public Health Act to establish licensing and regulatory guidelines for institutions that provide medical services.</p>

Area for Consideration	The Situation	Recommendation
Assessment and Motivation	The focus of the NHIS should not just be disease management but also to provide incentives for all stakeholders to do the right thing	<p>The NHIS would conduct satisfaction surveys for clients and service providers.</p> <p>Based on the results of the surveys, rewards shall be provided to professionals whose service delivery aids in the attainment of national indicators.</p> <p>Additionally, the NHIS should aid in the training and capacity building of health professionals.</p>
SOCIAL DETERMINANTS OF HEALTH		
Health Promotion	The provision of information to promote healthy behaviours would be critical to the sustainability of the NHIS.	<p>Financing: Sin Taxes are presently levied on gambling, lotto receipts, tobacco and alcohol. It is being proposed that a similar tax be imposed on sugary beverages and trans fats. The receipts from all of these taxes shall be earmarked for health promotions across the Federation. That is, revenue from this tax will no longer be deposited into the Consolidated Fund but into a new Fund designated Health Promotion and Innovation.</p> <p>Management: With approval for the Health Promotion and Innovation Fund, a Multi-sectorial Steering Committee shall be established to develop the annual work plan and budget for the utilization of the funds complete with the monitoring and reporting framework.</p>

Conclusion:

The National Commission for Universal Health Care invites consultation and discussion on the Green Paper. To schedule special presentations by the team and to share your comments and feedback please contact us at

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