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Abstracts and Reports

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The Role of Social Security in the Provision of Medical Care in the English-Speaking Caribbean

Provision of medical care to all citizens as a public service is a long-standing tradition in the countries of the English-speaking Caribbean and is usually the responsibility of the ministry of health. National health systems are composed mainly of public institutions; private hospitals and medical practitioners are always components of the systems, but their importance varies from country to country.

The economic crisis and consequent recession faced by the countries of the Region have affected the allocation of resources to health services, their sources of financing, and health expenditures in general, forcing governments to embark on policies designed to compensate by shifting part of the load onto the private sector. Paradoxically, evidence suggests that the public services are now facing greater demand owing to the economic downturn. As a result, deficiencies have become apparent in both the quality and quantity of services: staff and supply shortages, longer waits for appointments, and equipment failures are examples. A second result is that some health services have had to establish programs for cost recovery or cost sharing, such as user fees, which cover some portion of the cost of care and are paid by the user at the time of service delivery. Several private insurance and prepayment schemes have also been introduced.

The health systems in the Caribbean are thus in a stage of transition from primarily public-assistance systems to mixed models, in which services are financed by various combinations of public providers, private schemes, and national health insurance arrangements. Within this context, this paper reviews the current role of social security institutions in financing health care and explores possible alternative avenues for their participation.

HEALTH CARE FINANCING ARRANGEMENTS IN THE CARIBBEAN

The following are examples of the wide gamut of national situations that currently exist.

- In Jamaica, the Government, through the Ministry of Health, is the principal provider of health care services. The private sector is mainly

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involved at the primary care level through individual general practitioners and maintains a few private hospitals. The number of prepayment and private insurance entities is increasing. User fees for medical services were reintroduced in 1984 and resulted in a small but steady decrease in the demand for outpatient consultations.

- In Anguilla, pre- and postnatal care services are free of charge, as are services to children under five years old, diabetics, and hypertensives. For other patients, standard fees from EC$3.00 to EC$10.00 are charged for doctor consultations at clinics, and a minimum fee is routinely paid for drugs. Social welfare covers the 5% of the population that is unable to pay, thus guaranteeing full access to primary health care.
- In Dominica, where only 2% of individuals have health insurance, primary care and hospital services are free to all social security card holders, children, and persons recommended by the welfare division.
- In Belize, social security (initiated in 1981) finances only those health expenses related to occupational illnesses or accidents.
- In Martinique, Guadeloupe, and Guiana, 80% of medical care expenses are covered by the social security systems. The cost of preventive activities is shared by the State and local communities, which also bear the cost of free medical care given to residents not covered by social security.
- In Suriname, health services are financed from three sources: contributions by employers and the Government to the State Health Insurance Foundation, which covers 38.4% of the population; insurance schemes of private companies for employees and their families; and resources allocated by the finance ministry to the ministries of health and social affairs for services rendered to the poor.
- Bermuda has compulsory hospitalization insurance, 50% of whose cost is borne by employees. Schoolchildren receive free treatment, and 75% to 100% of the hospitalization costs of persons over 65 are subsidized. The private sector of general practitioners is significant.

SOCIAL SECURITY COVERAGE OF MATERNITY AND SICKNESS

Cash Benefits

The social security systems in the 12 countries listed in Table 1 provide cash maternity benefits to female workers, with the duration of benefits ranging from 8 to 13 weeks. In all these countries except Grenada and Jamaica, lump sum maternity grants of varying amounts are also paid. A few plans even make payments to wives of insured workers. The benefits generally amount to 60% of earnings, except in Jamaica where minimum wage is paid and in Barbados where 100% of wages are replaced.

All the countries except Jamaica pay cash benefits in the event of sickness. The duration of benefits is normally 26 weeks, but ranges from 13 weeks in Belize to 52 weeks in Trinidad and Tobago. A short waiting period (three to four days) is commonly required before this type of benefit is paid.

Except for the lack of cash sickness benefits in Jamaica, cash benefits from social security are the rule for maternity and sickness in the Caribbean. Generally, no separate contribution from wages finances these benefits, except in Barbados, where workers and employers each contribute 0.55%.

TABLE 1. Cash benefits for sickness and maternity payable by social security in some countries of the English-speaking Caribbean.

Country	Sickness benefit		Maternity benefit		Maternity grant paid
	% average wage	Weeks paid	% average wage	Weeks paid	
Antigua and Barbuda	60	26	60	13	yes
Bahamas	60	26	60	13	yes
Barbados	66.7	26	100	12	yes
Belize	60	13	60	12	yes
Dominica	60	26	60	12	yes
Grenada	60	26	60	12	no
Guyana	60	26	60	13	yes
Jamaica	—	—	minimum wage	8	no
St. Kitts and Nevis	60	26	60	13	yes
Saint Lucia	60	26	60	13	yes
St. Vincent and the Grenadines	60	26	60	13	yes
Trinidad and Tobago	66.7	52	60	13	yes

Source: U.S. Department of Health and Human Services, Social Security Administration, *Social Security Programs Throughout the World—1987*, Research Report No. 61, Washington, D.C., 1987.

Medical Care

There has been a clear tendency for social security institutions not to enter directly into providing or financing medical care. As noted previously, the great majority of the inhabitants of the English-speaking Caribbean countries traditionally obtain their medical care in installations of the ministries of health, while some more wealthy individuals utilize private practitioners and hospitals.

Nevertheless, some of the governments in the Caribbean have recently begun to investigate the possibility of establishing national health insurance schemes. In the Commonwealth of the Bahamas, a report discussing such a plan was presented in 1987. The Government accepted in principle the report's main recommendations for the establishment of a national health insurance plan and promoted public discussion to obtain reaction to its specific recommendations. The plan is projected to begin operation in 1991-1992.[1]

In Barbados a national health service has been discussed since at least 1976, when it figured in the platform of the political party that won that year's election. The idea was subsequently studied with the help of the Inter-American Development Bank. In a step to alleviate the high cost of medical care, the Barbados Drug Service was introduced in 1980. It prepares, maintains, and updates the National Drug Formulary, which is widely used in the country's health services, and is a good example of the gradual implementation of improvements in national health services based on a plan with specified goals.

Trinidad and Tobago is another country that is actively interested in developing some means of alternative financing for the health sector. Both the possibility of user charges for health services and the idea of a health surcharge on employed (insured) persons have been considered, the latter being a forerunner to the National Health Insurance Scheme (NHIS). A 1986 PAHO feasibility study found that, over time, health insurance would improve the efficiency, effectiveness, and

[1] Pan American Health Organization, *Health Conditions in the Americas, 1990 edition* (Scientific Publication No. 524, Washington, D.C., 1990), Bahamas country report, p. 30.

equity of the health care system and would allow a substantial shift of demand from public to private providers. Although NHIS has not yet been implemented, a health surcharge was levied on employed persons to help the Government pay for health services to the population.

Another development that deserves mention is the Medical Benefits Act of 1978 in Antigua and Barbuda, which levies a 2.5% contribution on both workers insured under social security and their employers. The total of 5% is used to reimburse insured persons (who have contributed for at least 26 weeks) for medical care expenses incurred from private providers or from the Government-owned hospital.

The following section discusses some other mechanisms besides cash benefits and the financing of medical care that might be used by social security to provide or finance health services.

ALTERNATIVE METHODS FOR SOCIAL SECURITY PARTICIPATION

Payment to Providers

Social security institutions could pay providers of care—individual doctors, groups of physicians, or ministries of health—for the services rendered to insured persons by means of a contract based on the volume of hospitalization and medical services furnished. The fee schedule employed is usually agreed upon in advance by the contracting parties, or is based on an estimate of total volume of services to be provided during a given period (six months or a year); the contract can then be renegotiated according to actual experience. For hospitalization, whether in public or private institutions, a price is agreed upon for each day of hospital stay, and payment is made according to the number of hospitalization days recorded or estimated. This fixed sum arrangement is used in Belize to pay the Ministry of Health for care provided to persons with work-related illness or injury. In Saint Lucia, social security contributes US$560,000 annually to the country's health ministry to cover health services for National Insurance Scheme contributors.

Many variations exist in the method of payment. In France and its affiliated territories in the Caribbean, insured persons are reimbursed about 75% of the expenses incurred. In the United States, Medicare also features a deductible: for hospital charges, the insured pays a fixed amount and the health care financing system pays the balance up to a limited number of days of hospitalization per year. For doctors' services, the elderly and disabled covered under Medicare pay a fixed amount of the approved charges and then 20% of the remainder up to a predetermined total, beyond which Medicare pays the bill.

Cost sharing and user fees are important and much-discussed aspects of any reimbursement scheme. On the one hand, they are designed to prevent abuse of the system, since people will be less inclined to seek care they do not really need if they have to pay part of the cost. On the other hand, these mechanisms set up a financial barrier that may restrict access to care for persons who do not have the required resources.

Social Security Facilities

As another method of providing medical care to insured persons, social security could maintain its own hospitals and outpatient clinics or dispensaries. This system is commonly used in many countries of Latin America. It is usually combined with the contracting of services, es-

pecially in small outlying villages or towns where it is not feasible to have two networks of medical facilities existing side by side. In two countries of Latin America (Costa Rica and Panama) where social security initially operated its own network, separate from that of the health ministry, it is interesting to note that over time the two systems were combined to make better use of existing human, medical, and financial resources. In the remaining 14 countries of Latin America with this sort of dual system, substantial efforts have been made over the last 25 years to coordinate or functionally integrate the health care resources belonging to social security with those of the ministries of health.

Any proposal to establish a new and separate system of medical care would require careful study of the current and historical situation and demographic, medical, and financial factors. The creation of an entirely new medical infrastructure has proven to be an expensive venture; in addition, physician consultations and hospital days always exceed advance estimates. The deficits resulting from chronic underestimation of medical utilization have been covered in many Latin American countries by using the reserves accumulated to finance future pensions.[2] It is highly unlikely that the countries of the English-speaking Caribbean area would find this alternative practical, considering its requirements in terms of medical personnel, infrastructure, and money.

Improvement of Existing Health Systems

The third main alternative way for social security to participate in health care is for it to provide the existing system with additional resources. The relatively high coverage of social security, in conjunction with the earning power of the employed persons it covers, would seem to open the way for the financial strength of social security to assist governments in improving the quality of the medical care they provide through ministry of health facilities. For example, a regular contribution by social security should enhance the ability of a government to secure loans for the improvement of health infrastructure. This assumes, of course, that such a contribution would be in addition to the normal budget allocation for health, and not in its place.

Coverage by social security in the Caribbean tends to be fairly broad, compared with that in Latin America, where, for example, 25% or less of the working population in 10 countries is covered.[3] Table 2 shows population, labor force, and social security coverage for some of the countries in the English-speaking Caribbean. While this data is to some extent

TABLE 2. Population, labor force, and social security coverage in some countries of the English-speaking Caribbean.[a]

Country	Population[b] (1988)	Labor force[b]	Labor force covered by social security[b] No.	%
Bahamas	247	94	80	85
Barbados	255	108	84	78
Belize	182	55	41	74
Guyana	799	260	146	56
Jamaica	2,429	838	481	57
Trinidad and Tobago	1,241	471	380	81

[a] The information in this table is based on data from an article by Michael Uenkins, "Social security trends in the English-speaking Caribbean," *International Labor Review* 120(5), Sept.–Oct. 1981. Population figures were updated to 1988 based on the World Bank, *World Development Report, 1989*, and the *World Bank Atlas*, 1989. Labor force and social security coverage figures were extrapolated on the assumption that they changed at the same rate as the population.

[b] Numbers in thousands.

[2] C. Mesa-Lago, *El desarrollo de la seguridad social en América Latina* (Economic Commission for Latin America and the Caribbean, 1985), p. 22.

[3] *Ibid.*, p. 270.

based on assumptions, it does show clearly that a significant proportion of the labor force (56% to 85%) is covered by social security in six countries, which means that measures taken to improve the health services for this group and their dependents will benefit the majority of the population.

Social security might provide a mechanism for obtaining additional financing to improve the health services available to insured persons, their dependents, and the remainder of the population. Strengthening the existing systems operated under the aegis of the ministries of health would seem to be the most appealing of the three alternatives considered for developing a system in keeping with existing resources. Policy decisions on such matters would require careful studies.

GUIDING PRINCIPLES

Based on the foregoing review, the following guiding principles are set forth for consideration:

1. In any arrangement between a ministry of health and a social security institution in which the latter defrays all or part of the cost of medical services provided to insured persons, there should be tangible improvement in the services resulting from the infusion of additional funds. To expect social security to pay for services that are exactly the same as those offered before such payment is to invite criticism and dissatisfaction.

2. A fundamental starting point in restructuring health services and coordinating the resources of the ministries of health and social security institutions should be implementation of a national health policy that aims to improve the health situation of the entire population; provide adequate health care as a basic human right for all citizens, regardless of their ability to pay, thereby correcting imbalances and social disparities in the health care delivery system; and make the overall management of health services more efficient.

3. Consistent with the above, it is neither necessary nor desirable to establish two distinct systems of care, one for uninsured persons and a second, higher level for insured persons. This situation would constitute discrimination among citizens of the same country, sometimes between members of the same family. The objective should be to establish one efficient and equitable system of medical care, which additional funding from social security should help to achieve.

4. Social security institutions in the Caribbean area should take note of the experience inside and outside the Region and not try to operate their own facilities. Even in large countries, this practice has proved costly, depleting reserves set aside to finance the pensions of future generations.

5. Some mechanism or procedure must be used to keep costs under control. A system providing unlimited, open-ended fee-for-service payment or reimbursement is equivalent to a blank check. Some poorly considered reimbursement schemes have had to be abandoned after a very brief period of experimentation. It is better to initiate a cautious program than to try to restrict benefits once they have been conceded. Cost sharing and deductibles are useful mechanisms.

6. Frequently, the point of interface between a social security institution and the medical care services operated by the ministry of health is the diagnosis of a medical practitioner, on the basis of which social security decides to replace part of the wages lost during periods of sickness. Careful consideration must be given to where to place this important financial power. The judgment of the physician must be made without pressure and as objectively as possible.

7. At the present time, most national legislation makes a distinction between ordinary sickness and injuries and those related to employment. Usually, more favorable benefits and more complete medical care are accorded to work-related illnesses and injuries. Benefits for the latter are usually financed entirely by the employer, whereas insurance for ordinary sickness and injury is shared between worker and employer. It is open to question whether continuing to make a distinction between these risks is necessary or desirable. Why should the treatment or compensation be less in one case than in the other? Frequently, long and costly litigation is required to determine the origin of an illness or injury. Elimination of the distinction would have as a central aspect the adequate design and implementation of occupational health programs, as well as their integration in the overall development of health services.

CONCLUSIONS

In the face of budgetary limitations on the medical services provided by the ministry of health, it is natural that consideration is being given to the relationship of social security to medical care in the English-speaking Caribbean. Feasibility studies have been done in some countries, and steps toward a closer relationship have been taken in a few. Nevertheless, wider and more systematic research is required, not only on economic and financial implications but also on the best alternatives for organizing and providing services so as to incorporate advances in medical and health knowledge and at the same time rationalize their utilization.

Quality medical care is everybody's concern and right, but, like so many other benefits, it has a price—and a constantly increasing one. Thus, new sources of revenue are needed by the ministries of health. A small additional contribution from the salaries of the employed population might be a practical way of breaking the bottleneck of medical care and giving the ministries of health a financial "shot in the arm" to enable them to provide better organized, more efficient, and more effective medical services to the population of the English-speaking Caribbean.

In pursuance of policy decisions by its Governing Bodies, PAHO is prepared to continue cooperating with social security institutions in Member Countries in this endeavor, and also to coordinate its efforts and resources with other international agencies to support national actions to achieve these goals.

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Prevention and Control of Hospital Infections in Latin America and the Caribbean

The Pan American Health Organization/World Health Organization, in a joint effort with the Society of Hospital Epidemiology of America (SHEA), organized the Regional Conference on Prevention and Control of Nosocomial Infections. The meeting was held at PAHO/WHO Headquarters in Washington, D.C., from 11 to 15 December 1989, and was attended by professionals from

Source: Condensed from "Prevention and Control of Hospital Infections in Latin America and the Caribbean," written by Dr. Humberto de Moraes Novaes, PAHO/WHO Regional Adviser in Hospital Administration and Health Systems, Washington, D.C., June 1990.