Anguilla Health Sector Review 2011

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All currency is expressed in EC$ unless otherwise specified.

Acronyms

CE	Chief Executive
GOA	Government of Anguilla
HAA	Health Authority of Anguilla (a Statutory Authority)
MOHSD	Ministry of Health and Social Development
NHF	National Health Fund (a Statutory Authority established as a hybrid NHI)
NHI	National Health Insurance (a system where health care for all is funded from payroll deductions)
PAH	Princess Alexandria Hospital
PHC	Primary health care (first-contact health care encompassing prevention)
SA	Statutory Authority

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Anguilla Health Sector Review 2011: Summary

History

Successive governments have been concerned with improving the quality of health care services and with achieving universal access for all citizens. Over a decade ago, studies were undertaken into the feasibility of introducing a national health insurance (NHI). As a result, a major first step was taken to introduce the Health Authority of Anguilla (HAA) in 2004, transferring the provision of services to a statutory authority, aiming to allow service managers to operate free of public sector constraints. Initially, the HAA was contracted by the MOHSD, but with the intention of establishing a NHI agency for that purpose in due course. In 2008, the National Health Fund (NHF) was designed to fulfil that role. It was designed as a hybrid NHI because it was clear that a pure NHI – in which care for all is financed from payroll reductions with government paying the contributions of the indigent - would require such large payroll deductions as to be unacceptable to employers and employees and would result in compensatory wage increases significantly reducing the price competitiveness of the tourism industry. At today's prices, for example, something like 16% would need to be deducted from insurable earnings to pay for a national health care system.

To achieve universal coverage and access, the NHF was designed to be financed by a smaller payroll deduction of 6% with a fixed annual subvention to the NHF by GOA from the Consolidated Fund replacing all current GOA health expenditure. The NHF was designed as a health services purchasing organisation, procuring services from the HAA and from purely private providers alike to defined quality standards and prices, and including overseas specialist care when necessary. The medical expertise of the NHF would introduce new ways of paying health care providers emphasising payment for preventive services just as much as curative services, the only way to begin to relieve Anguilla's emergency chronic illness burden.

The NHF was designed as an independent organisation rather than as part of the Social Security Board (SSB) to ensure that finances for health are entirely separate from those for social security purposes, with no possibility of health needs eating into social security funds. Whilst social security must accumulate a large capital fund invested to facilitate future payment obligations, health funding is money-in money-out with no accumulation of capital save that sufficient to smooth irregularities in monthly costs. International good practice recognises the risks of operating universal NHI within social security organisations and, indeed, any use of social security funds for health care may risk legal action or judicial review by those whose contributions are so used. Moreover, NHI requires specialist and on-going health purchasing expertise acting through pro-active mechanisms for prevention and improving health, not after-the-event payment mechanisms for services. In order to avoid unnecessary duplication of functions, the NHF was designed to sub-contract SSB to undertake the registration of those eligible for NHF funded health care, and to maintain this register, functions that SSB is experienced in.

The Health Sector Review 2011

Initially, the HAA achieved improvements in services as demonstrated by the results of consumer satisfaction surveys. Of late, however, it has suffered from a number of weaknesses culminating in GOA appointing a Health Advisory Commission Report (July 2010) to advise on its future. This Health Sector Review 2011 endorses many of the findings of that Commission, particularly with regard to the limited performance of the HAA, which remains the single biggest provider of health care services.

The Sector Review concludes, however, that the root causes of the malaise of the HAA today are that it is **not independent enough** and **not incentivised enough**.

It is not independent enough because, through the board members, GOA exerts unnecessary and partisan influence over the operations of the HAA and its ability to make rational management decisions to

improve quality and cut costs. Rational attempts by HAA in the past to improve have been stymied in this way.

The HAA is not incentivised enough because it receives its GOA subvention regardless of its performance and, as a result, continues to behave as if it were still part of the civil service with few rewards or sanctions for staff related to their performance.

The answer to this is to make the HAA completely independent and make it earn its income through its performance. There must always be the threat that if the HAA cannot perform, public finance will seek some services elsewhere.

For this to work, public finance must be channelled through a competent technical funding body with the ability to ensure performance is achieved for the finance received by providers. The National Health Fund was designed to fulfil that role on behalf of GOA and tax payers, and this remains the best solution although there are options in precisely how it fulfils that function.

Options for the structure of the HAA

- An independent charitable trust – a form of non-profit company with no shares
- A company with shares all owned by its staff but that cannot be traded
- A private company owned by shareholders with shares that can be traded
- A mutual society owned by all contributors, ie. those paying the proposed health contribution from earnings
- A combination or variation of these.

If any of these forms has a board – and it is by no means clear that this is needed – then board members should be selected by shareholders (or the equivalent) not by GOA ministers. GOA should exert influence through national policy and by transferring all health expenditure through the NHF, leaving health care providers free to manage within the context and incentives set by the NHF on behalf of consumers.

It is recommended that the option for the HAA that would best combine real independence to solve problems, improve quality, and contain costs in response to the incentives that will be put upon it by the NHF would be a company with non-tradable shares owned by staff. This would create the internal incentives for staff at all levels to perform, and would transform the culture of the HAA.

Options for the NHF

Without something like the National Health Fund, Anguilla will not get value for money for its health expenditure. The NHF must have the technical knowledge to spend public money to get the best result. It will incentivise the HAA, because for the first time, there will be the threat that if HAA can't provide good value for money, more of the available health budget will be transferred to some private providers who can.

The pressure will be on for the HAA to be efficient and consumer friendly because it needs to attract consumers – if it fails to keep consumers happy, they will go to the private providers, NHF funding will follow them and HAA will lose some of its funding. In response to NHF pressures to be efficient and raise quality, an independent HAA would be inclined to take some actions it is not allowed to take now. These would include, for example:

- Centralising all the best primary care skills and equipment into one health unit and closing all the small units it operates now – small units are dangerous medicine. One national primary care centre would provide full medical cover and a full range of preventive and curative services. This would be presented to the consumer as a major advance towards modern medicine.

- Streamlining hospital procedures around patient needs not traditional practices that benefit staff more than patients. Actions would include reducing the numbers of beds and associated staff – currently the hospital operates at 30% occupancy, suggesting surplus capacity, and encouraging unnecessary admissions.

- Contracting out some of its services to private doctors who can do them better. This might include specialist diagnostics and outpatient consultations but might also include some surgery and other treatments. It might also include buying the time of some private doctors to be on-call at night at the end of a cell phone for accident and emergency (A&E) services, enabling reductions in full-time A&E doctors, a major cost currently.

Under NHF spending pressures, health care in Anguilla would look very different in a few years, with private providers competing for some core services in both primary and secondary care, and with an independent HAA providing a tightly managed, consumer oriented service.

The main options for how NHF could do this are:

1. To have a direct medical purchasing role: NHF will negotiate directly with the providers of services including overseas services.

2. To negotiate with an insurer to provide health insurance for everyone – Anguilla is already spending around $54m a year ($24.6m GOA and $29.4m privately), which would be enough to purchase basic insurance for all.

The first option was the original plan for the NHF and is a good and cost effective one if the right skills can be found to lead the organisation, and if the NHF structure allows decisions to be made on a technical, value-for-money basis without partisan influence or constraint. For this reason, if this option is selected, and if the NHF structure remains a Statutory Authority as conceived currently, then there is a very strong case that board members should be selected by representatives of the businesses and consumers who will be paying the 6% health contributions through payroll deductions on earnings.

The second option for the functioning of NHF has advantages of the relative ease with which it could be established and its likely initial attraction for consumers. It is, however, a very expensive option and it will be very deficient in achieving the main objective of health care to prevent illness. With chronic illness now an emergency situation in Anguilla, this is a serious defect – delaying dialysis for one patient by one year through preventive and early diagnosis measures saves $234,000 for example.

It is recommended that Anguilla should continue with the original concept of option 1. It is recognised, however, that the role of NHF is quite difficult technically, and the NHF Board will need some support. A very practical option to get things started would be to appoint a health management company for a period of 18 months to directly run the NHF during the transition period. Part of its brief would be to find a suitable Chief Executive to take over. At the same time, the health management company could support the transition and management of the new health company formed from the HAA.

Costs and financing

Best estimates indicate that with a NHF in place as an efficient purchaser, Anguilla could obtain adequate health care for around $40-45m a year at 2010 prices. This could be financed by capping but maintaining GOA 2010 expenditure levels of around $25m for all purposes, plus a 6% health levy on earnings, both directed through NHF, and smaller contributions from patient co-payments paid directly to providers. The $25m is a significant reduction in total GOA expenditures on health in earlier years. It would need to rise with inflation and would be subject to annual negotiations between GOA and NHF based on

experience being gained. It is vital that any annual variations are small to allow planning and contracting by NHF and predictability of funding for providers allowing them to invest to meet NHF quality standards.

Cost control will be an integral part of the NHF work. Various 'levers' are available to NHF. Excessive demand for primary care can be dampened if necessary by increasing consumer co-payments to service providers. Excessive overseas tertiary care costs can be contained by NHF not approving referral for expensive cases with poor prognosis. Ultimately, control can be exercised by withdrawing specific medical conditions from NHF coverage.

As this Review explains, there are some savings to be made in the costs of health care now. These should be achieved by putting the right incentives in place for the long term so that cost containment and value for money become embedded in the health care system as summarised above and in more depth in the body of this Review. Without this, funding demands on government will rise relentlessly, and much expenditure, public and private, will be spent to little effect. A lot has been learned over the last few years, and the required direction for change is clear. It will require a strong, long-term vision by the current administration to take the steps needed, but the potential rewards are great.

Background to this Review

The Government of Anguilla (GOA) seeks a package of budget measures to achieve a budget surplus by the beginning of 2013. Following the visit by DFID-funded revenue and expenditure experts in February 2011, one of the central budget measures identified by GOA was the need for a preliminary programme of health service reorganisation.

There have been concerns for several years about the performance of the Health Authority of Anguilla (HAA). In 2010, GOA appointed a Commission to look at the future of the HAA including the possibility that it should revert to the public service. The Commission's view was that it should not, and several alternative proposals were made on which decisions have not yet been taken.

The Chief Minister of Anguilla has expressed the need to explore the possibility of moving towards some kind of 'national health service' to replace the present patchwork of public and private sector provision, which leaves much of the population with inadequate health insurance, and bills for treatments in the public health system unpaid.

DFID and the UK Foreign and Commonwealth Office agreed to provide GOA with technical assistance for a preliminary phase of health service reorganisation, and the MOHSD prepared terms of reference for this Anguilla Health Sector Review 2011 specifically to:

- assess the current state of health care systems and their cost to government;
- assess options for the future delivery and financing of health care based on their likely relative costs and effectiveness; and
- prepare a timetable for executing the recommended options.

1. The current state of health care

Health care needs

The disease burden in Anguilla is mainly that of chronic non-communicable diseases and conditions. The leading causes of death are heart disease, hypertension and stroke, diabetes and cancers. Most of these are inter-related: hyperglycaemia and diabetes are important causes of mortality and morbidity, through both direct clinical sequelae and increased mortality from cardiovascular and kidney diseases. With overweight and obesity common, concern has to be raised about a diabetes epidemic, significantly reducing life expectancy and quality of life, and inflating health-care costs.

Both incidence (new cases per year) and complication rates of these chronic diseases are higher than they need be. Dealing with them requires new ways of providing services – they cannot be cured by a hospital admission and procedures in the way that acute communicable infections can. Reduction in morbidity and premature mortality require lifestyle change by individuals, prevention efforts by primary care providers, plus earlier diagnosis, treatment, management and rehabilitation services. Without these, premature deaths and disabilities will rise, and costs will spiral.

Whilst specialist expertise has a role, the mainstay of care for chronic diseases has to be the primary or community care team, supported by patients themselves with better knowledge about managing their conditions. A key feature of the future health care system of Anguilla must be that care providers are rewarded for prevention not just treatment.

Expenditure

In 2010, health expenditure was about $54m, comprising $24.6m through the GOA Consolidated Fund, and $29.4m through individual and corporate insurance premiums and out-of-pocket direct payments for

services (see Table 1). GOA expenditure is mainly through an annual subvention to HAA and the insurance cover for civil servants, but also includes money channelled to HAA from the Department of Social Development. In recent years, GOA expenditure has been significantly higher (around $29-30m) but in 2010, GOA allocation to the HAA was cut from $21m to $16.8m, although it remains to be seen whether HAA was able operate within that budget without significant increase in its debt to creditors, and/or what effects this has on services.

Table 1: Sector expenditure by sources and applications 2010

row number	Sources of funding:	Number	Expenditure by service provider in EC$:					Total expenditure EC$:	
			Anguilla				Overseas		
			HAA			Private		by GOA	by consumer
			PAH	MGMH	PHC				
1	**GOA transfers and reimbursements**	12,300							
2	GOA allocation to HAA	12,300	12,600,000	840,000	3,360,000			16,800,000	
3	MOHSD Account 36103: medical treatment (prisoners)	50	107,812		107,812			215,623	
4	MOHSD Account 36102 for school dental				202,353			202,353	
5	MOHSD Account 36101 Medical Treatment Overseas						933,325	933,325	
6	DSD for medical exemptions		536,146					536,146	
7	DSD for dialysis		1,324,000					1,324,000	
8	DSD for medical treatment overseas						132,418		
9	Civil service workers insurance plan	1,130	462,320		462,320	1,849,279	924,640	4,623,198	-
10	**Private insurance:**								
11	paid by statutory authorities	360	147,312		147,312	589,248	294,624		1,473,120
12	paid by SA employees for dependents	360	33,674		33,674	134,694	67,347		336,735
13	paid by private sector employers	2,020	826,584		826,584	3,306,336	1,653,168		8,265,840
14	paid by private sector employees for dependents	2,020	188,946		188,946	755,784	377,892		1,889,459
15	paid by Civil Servants to cover dependents	1,130	105,697		105,697	422,790	211,395		1,056,975
16	individual 100% self pay insureds	490	200,508		200,508	802,032	401,016		2,005,080
17	paid by self-pay insureds for dependents	490	45,833		45,833	183,334	91,667		458,334
18	**Consumer out-of-pocket**								
19	Expenditure at HAA								
20	100% fees to HAA by uninsured		2,185,658		745,502				2,931,160
21	20% co-payment fees to HAA by insured		290,863		99,210				390,073
22	Expenditure on private doctors on Anguilla								
23	100% fees to private doctors on Anguilla by uninsured					1,846,414			1,846,414
24	20% fees to private doctors on Anguilla by insured					245,717			245,717
25	drugs expenditure in private sector by uninsured					461,603			461,603
26	drugs expenditure in private sector by insured					61,429			61,429
27	Expenditure on doctor visits overseas								
28	100% fees to private doctors overseas by uninsured						1,384,810		1,384,810
29	20% fees to private doctors overseas by insured						184,288		184,288
30	drugs expenditure overseas by uninsured						461,603		461,603
31	drugs expenditure overseas by insured						307,147		307,147
32	Expenditure on specialist care overseas								
33	uninsured self pay						4,995,825		4,995,825
34	insured co-payments @20%						664,835		664,835
35	Total expenditures		19,055,353	840,000	6,525,751	10,658,660	13,086,000	24,634,646	29,420,448
36	**Total national expenditure**								**54,055,094**

For assumptions, sources and commentaries by row, see Annex 1.

Highlighting the financial impact of chronic diseases, Anguilla is spending $2.8m a year on dialysis alone (assuming 12 patients throughout the year and costs of $1,500 per session three times a week), equivalent to 16.7% of GOA allocation to HAA in 2010, and 11.4% of GOA total expenditure on health. The number of people requiring dialysis is likely to increase significantly over the next decade and beyond if large-scale and effective prevention measures are not implemented urgently. This is discussed later.

Based on the estimated total population of 15,000, Anguilla spends $3,604 per capita per annum on health (US$1,335) putting it on a par with Barbados (US$1,500) and the Baltic countries, and above Poland and other Eastern European states, Argentina, Costa Rica, and other Caribbean states. Based on an eligible population of 12,300 (estimated 10,500 nationals, 1,440 work permit holders and 360 of their dependents), Anguilla spends $4,395 per capita on health (US$1,628), more than Barbados and other countries mentioned above. The UK spends around US$3,222.

If GNP is around $784m, Anguilla is spending about 6.9% of GNP on health, again similar to Barbados, Baltic and Eastern European countries but less than Western European countries (9-10%). The UK spends about 8.7% of GNP on health.

Quality and value for money

Health care services are supplied by private doctors and the HAA on Anguilla, and by providers overseas. Key issues of quality and value for money include the following.

Health Authority of Anguilla

Primary care services are being provided from too many small units, with the result that some are seeing very few patients. This is not good practice, and quality would be better and costs reduced if these units were consolidated providing maximum medical and nursing cover, and the best staff and equipment.

The Princess Alexandra Hospital (PAH) attempts to operate more beds than are needed for the caseload generated by the population for the services it can safely offer. This is reflected in low occupancy rates. Quality of care would be better if bed and related staff numbers were reduced resulting in higher utilisation rates and productivity levels based on busier and better-practised staff.

Private sector on Anguilla

About 10 private doctors are practicing actively. All are trained specialists but function as primary care providers as well as in their specialism. On the whole, this is not desirable practice, but there is no tradition of general practice, and consumers generally self-refer to doctors because of their known specialism or because of family or historic reasons.

Most of the private doctors operate as sole practitioners without much medical or clinical support, a situation that could be improved by encouraging development of joint practices with larger volumes of patients justifying enhanced clinical support and equipment.

Overseas care

Primary, secondary and tertiary care are also obtained overseas, ranging from a visit to a favoured doctor on St Maarten to hospital inpatient care in Puerto Rico, mainland USA or elsewhere in the Caribbean. It is paid for by combinations of out-of-pocket payment, insurance or GOA assistance. Whilst the quality of care obtained in these destinations is usually satisfactory, value for money may not be.

A fundamental problem is that much care obtained by Anguillans – on Anguilla and overseas – is being bought without much consumer knowledge about what is really needed and who provides it best and at reasonable cost. No agency is available as a knowledgeable purchaser or regulator to ensure the quality and price of services meets minimum standards and adequate value for money, including the services provided by HAA with direct GOA funding.

A second major problem with quality is the lack of incentives and systems for prevention, early diagnosis and management of chronic conditions. Consumers seek care under fee-for-service arrangements, and doctors' income is geared to that. Care is episodic rather than continuous because patients may resist being properly managed when each visit costs another payment.

There are questions too about the proper balance of on-island versus overseas care, and these are likely to be raised more and more as technologies and medical capabilities evolve. In some bigger countries, including the UK, conventional general hospitals are beginning to be squeezed as more diagnosis and treatment becomes possible by general practitioners who will then, when necessary, refer directly to

centres of specialist expertise rather than to the general hospital. To some extent, this could also be desirable on Anguilla, especially if providers were to combine and collaborate more creating viable sized practices with adequate cover thus allowing more services to be provided on island.

Some of these issues will be addressed further in looking at structural options for future health services.

2. Options for improvement

2.1 Structures and incentives

Over the last decade, Anguilla has made serious attempts to improve the health care system. The introduction of the HAA in 2004 was an attempt to bring in management practices without the constraints of operating within the public service. This met with some early success as shown by improving consumer satisfaction surveys. More recently, however, significant improvement appears to have halted, resulting in GOA establishing a Commission to look at whether the HAA should be taken back into the public service. The review concluded that it should not and, instead, proposed more of an 'executive agency' structure and role. [Health Advisory Commission Report, GOA, 9 July 2010. See also: Technical Health Team Report on Dismantling the Health Authority of Anguilla, Ministry of Social Development, 2010]

This Anguilla Heath Sector Review 2011 agrees with many of the findings of the Commission, and certainly that the HAA should not be taken back into the public service. In fact, the fundamental problem appears to be that the HAA is not independent enough: the institutional structure of the HAA prevents it making and taking hard decisions even if it wanted to. This is not just a matter of the quality of management, but of organisational structure. The HAA is still overly controlled and constrained by whichever GOA ministers are in power, resulting in constantly changing and contradictory objectives, and tensions and blame shifting from one to the other. Sensible changes to services proposed by the HAA in the past have been prevented by political concerns about vote winning or losing. GOA ministers appoint board members based on maintaining control rather than on members non-executive skills. Because of this GOA control, HAA staff still consider themselves as public sector, or at least exhibit public sector behaviour and expectations when it comes to earnings and working conditions. The whole 'HR language' of the HAA is steeped in public sector allowances, gratuities, and travel and subsistence payments. A brief 'organisational self analysis' extracted from meetings and interviews with HAA senior management is provided at Annex 2.

At the same time, it has not been put under sufficient informed pressures to perform in return for funding from GOA: there has not been a 'knowledgeable purchaser' spending public finance on health. In recognition of this latter problem, and as a practical variation of a national health service, a National Health Fund was designed in 2007. The aim was to channel all GOA health funding, plus an additional income levy, into the Fund. The Fund would then act as a knowledgeable purchaser (and third party payer) of services for the whole population. The Fund would contract with on-island and overseas service providers. In practice the Fund arrangement would divert much of what is now spent inefficiently by individuals and insurers, and aim to spend this more effectively for the whole population. A NHF Act has been passed and Board members appointed, and it appears to be the intention of GOA to introduce the Fund.

The Fund concept remains likely to be the best way forward for Anguilla. It allows expenditure caps and built-in incentives for prevention and other aspects of quality. If managed by an experienced medical commissioner, with success judged on performance, and free from GOA operational interference, it could dramatically improve the quality and cost effectiveness of health care for all citizens. There remain a number of potential weaknesses in the Fund model – not least its structure as a Statutory Authority with board members appointed as outlined above for the HAA – but these could be overcome by changing the appointment mechanism. Also, there are options for how the Fund works, one of which might include purchasing insurance for the whole population. These are considered later.

In considering options for the way forward it is advisable not to lose sight of the key incentives needed in a cost effective health system. Providers must be free to manage their businesses and this is as true for the HAA as for the private doctors. Providers must have financial incentives to do the right things, and this means they must be paid for prevention and keeping people healthy rather than on the basis of an outdated fee-per-consultation or fee-per-item-of-service model. Providers must be contracted and paid by a purchaser with expertise in doing this, and who can ensure that public funding is going to the best-value-for-money providers (which does not mean the cheapest necessarily) and who can negotiate risk-controlled contracts with needed overseas services.

2.1.1 Options for HAA in terms of organisational and legal structure

Remaining a Statutory Authority but with a new board appointment mechanism

The HAA could remain as a Statutory Authority but become more independent by reducing direct political influence in the appointment of Board members. Instead, board appointments could be made by representatives of commerce, industry, and consumers. These are all 'stakeholders' with an interest in the health of employees and families and therefore in the performance of the HAA as one of the main health care suppliers. Whilst politicians may not take to this idea easily, it is surely legitimate to ask how they could expect any business to function effectively with the constant threat of partisan veto over technical and managerial operations, exerted on a basis of shifting and short-term political concerns rather than effective and sustainable improvement in health. They do not expect to have such control over private doctors but these are just as much part of the health system as is the HAA.

The number of board members could be reduced to three or five, and individuals selected on the basis of their experience in non-executive roles. Remuneration levels should be reduced to make this role more of a voluntary one rather than making a significant contribution to income, thus reducing incentives for patronage. The Health Advisory Commission Report, GOA, 9 July 2010, recommended something similar.

It has to be noted that, given the way boards typically appear to function in Anguilla, there is a strong argument that they could be dispensed with. Rarely do members function as wise and experienced non-executives, challenging chief executives constructively and providing useful advice and insight into good business and management practices. Once the NHF is functioning, the HAA will no longer be receiving public funding automatically through its subvention. That money will be spent by the NHF whose purchasing powers should ensure that performance and value for money are being produced. The HAA will be in competition with private doctors for NHF funding, and the latter do not have boards.

As a completely independent company or mutual fund

Several alternative legal structures were considered before the HAA was established as a SA. These included:

A charity – a company limited by guarantee

This is essentially a charitable or non-profit company with no shareholders but with a board of trustees. This tends to be the structure of NGOs involved in charitable work. Their status is tax-advantageous and to achieve this status they must satisfy legal requirements – in the UK they must satisfy and be registered with the Charity Commissioners, for example, which ensures that their activities are genuinely charitable. Any excess revenue over expenditure must be re-invested in the organisation or spent on similar charitable work. Since there are no shares to sell, all capital investment must be raised from profits or donations but, as noted, these may be untaxed. In the UK new forms of this model are being called 'social enterprises', and there are well over 60,000 of them working in various fields.

A company with shareholders

The organisation would be incorporated as a private company limited by shares, and shares sold to interested investors. The NHF would monitor the company's performance to ensure that its incentive for

profits did not result in low quality services, and would maintain the threat of moving its contract elsewhere if performance is inadequate. NHF would do the same for all other providers.

Shareholders would elect executive and non-executive directors replacing board members, and would bring pressure on the CEO to ensure performance. Shares could be traded at market value.

A company with shares owned only by staff

In this model of a company, shares are allocated to staff in proportion to their seniority and salary level. Dividends are paid at year-end based on the profits made which also forms the basis for fixing share value for the forthcoming year. When staff members leave, they must sell their shares back to the company at that value. They cannot sell them outside the company. When new staff members arrive, they are allocated shares as part of their package, which could mean an initially depressed salary to earn their shares. The company would maintain a pool of unallocated shares to enable these mechanisms to work. Under this arrangement, all staff members have a direct incentive to make the organisation efficient and attract consumers through receptive, consumer-friendly attitudes. As shareholders, staff would elect executive and any non-executive directors internally. Since there are no shares to sell, all capital investment must be raised from profits, and profits would be subject to normal taxation.

A mutual society

A mutual society is owned by all its financial contributors. This structure was commonly used by insurance organisations in that all assets are owned by the premium holders, and for mortgage organisations owned by mortgagees. Set up as a mutual society, the HAA would be owned by all its financial contributors, which could be defined as all those contributing to the NHF through salary contributions. Since there are no shares to sell, all capital investment must be raised from profits, but if there are profits in excess of investment needs they can be returned to members in the form of lower contributions for the following year. One problem experienced with mutual societies is that whilst legally members may vote on all major issues, in practice they have less incentive to do this than do shareholders in a conventional company for example. Management can become a law unto itself and has few incentives to control costs.

Options for HAA in terms of the organisation of its functions

To a greater or lesser extent, all these options above would put the HAA on a more equal competitive basis with private doctors, create incentives for efficient performance, and provide the NHF with better choice and leverage over quality including prevention.

In addition to these options for legal and corporate structure for the HAA, there are options for how its business is organised. One option that might be explored is to separate primary care from hospital care and have a separate organisation for each, totally independent of each other. This would make the primary care organisation compete more directly with private doctors (on Anguilla and on St Maarten and other islands) and on a more even playing field. This would raise standards and cost efficiencies. The incentives to concentrate skills and equipment would be overwhelming, perhaps accompanied by transport arrangements to attract more distant patients.

It would leave the PAH with the clearer role of running a small hospital, more able to respond to demands imposed by the NHF, and more inclined and able to buy time and services from private doctors if that complements and contains the cost of the services package being funded by NHF.

Making it happen

If GOA decides to adopt the strategy of independence for the HAA, arrangements will have to be put in place to make it happen. It is clear that GOA public sector skills are not available for this – key civil servants are already stretched with normal duties and many of the implementation skills required are not present. GOA should consider appointing a health management company for a limited period to drive the

change and to run the new company until systems are established and a Chief Executive contracted and in place. The management company will oversee the legal and human resource changes using local legal and accounting skills, and will push for the HAA to operate as a new independent company as quickly as possible with staff on new contracts.

Whilst this may appear an expensive solution, it is not clear what the alternative could be. Moreover, the potential savings and efficiencies easily outweigh the costs. It would also allow time to specify, identify and appoint the right Chief Executive and other key staff. Later in this Review it is suggested that a similar arrangement is necessary to get the NHF up and running and that the two support operations could be run in parallel by the health management company. A draft terms of reference is provided in Annex 5 to explain this suggestion in more detail.

Recommended option for the HAA

It is recommended that the option for the HAA that would best combine real independence to solve problems, improve quality, and contain costs in response to the incentives that will be put upon it by the NHF would be a company with non-tradable shares owned by staff. This would create the internal incentives for staff at all levels to perform, and would transform the culture of the HAA. Further explanation of how a company owned by its staff can work is provided at Annex 3.

2.1.2 Options for purchaser arrangements

Getting value for money from the providers of health services requires adequate technical capacity and independence of operation in buying services from them. The current plan for this 'purchaser' function is the National Health Fund. Details of how it would function were provided in the NHF Manual of Intentions and Procedures, 2008, and in the NHF Act 2008.

NHF as purchaser of health care services

The principles of the NHF remain valid and, if run by an experienced medical purchaser, the NHF could start to improve quality and contain costs quite quickly. Since NHF funding will come through the GOA fiscal apparatus including laws requiring payroll deductions, there is a much stronger case that the NHF must act more as an arm of government (than the HAA). At the same time, however, we have seen the disadvantages of the SA structure noted above. The NHF must be charged with buying health care in the national interests, but there should be no short-term party-political interference with its technical management and decision taking. There is no right answer for the 'checks and balances' needed here, but if the SA structure is maintained, then at least the board appointment mechanism should be revisited to ensure that members are selected by and represent consumer and tax payer interests directly as the key stakeholders in the whole enterprise. Also, board member numbers should be minimal and remuneration should reflect civic duty rather than represent a significant income supplement. There should be a statutory obligation for the NHF to publish the full facts of its operations and to hold public meetings annually at which board members and the executive can be called to account. The above would require minor amendments to the NHF Act.

As originally designed, the NHF would be run by a medically qualified CEO with experience in medical purchasing, and supported by a very small staff. Currently, NHF thinking is that a general manager could fill this role. The collection of payroll deductions and the registration of NHF-eligibles will be contracted to the Social Security Board that is already set up for these functions. NHF eligibles are Anguillans living on Anguilla and non-nationals on work permits and contributing to GOA revenues, and their dependents. The NHF will issue contracts with all service providers on Anguilla and overseas. The NHF will define needs and negotiate prices directly with providers. It will monitor results and manage problems as they arise, and will constantly seek to raise standards and contain costs, partly through rewarding providers for prevention and early intervention and management.

A NHF established in this model could also provide medical advisory services to MOHSD if it is decided not to have a Chief Medical Officer position within the civil service, the conventional situation in many countries, and that now proposed by MOHSD. This would have advantages of advice being independent, unhindered by vested interest or line responsibilities in the public service. It would also be cost effective, saving the salary of a CMO. Against that, MOHSD sees advantages of a CMO reporting to the PS and thereby under public sector directives.

This Review recognises that setting up and running the NHF functions is not an easy task. To get it established and operational, the NHF Board could consider contracting in a health management company with the requisite knowledge to manage operations for the first 18-24 months. As well as driving the change process, setting up systems and negotiating with providers, the company would assist in the appointment of a long-term Chief Executive to continue. As suggested earlier, this support could be combined with support to set up the HAA as a company and manage the services through the transitional period. Draft terms of reference are provided at Annex 5.

NHF as purchaser of insurance

An alternative is that, instead of hands-on negotiating and contracting with providers, the NHF could tender and negotiate wholesale insurance cover for all eligibles, leaving it to the insurer to pay providers and to contain expenditures.

Box on private insurance

For $45.3m a year, the NHF could purchase health insurance for all the 12,300 eligible population comprising resident Anguillians (10,500) plus foreign employees on work permits contributing to GOA revenues (1441), and their dependents (360). This assumes a 10% deduction in current premium rates of $341 per month is negotiable for the increased volume of business and spreading of risk. GOA is currently paying around $25m towards health, so would need to raise an additional $20m through fiscal measures. Current GOA, SA and private company insurance could then cease. Co-payment of 20% by consumers would continue and would provide a balance to unnecessary use of services by individuals. Competition between insurers bidding for the contract would maintain value for money. HAA would have to become completely independent as a company or non-for-profit organisation receiving no subsidy from GOA but earning its income from payments by insurers and co-payments, and operating in competition with private doctors for these payments.

Current annual national expenditure on health (GOA and private out-of-pocket) amounts to $5m (see Table 1), which is around the cost of providing the whole eligible population with private insurance (see Box). Since only half of this amount is funded through the Consolidated Fund currently, another $25m would have to be raised through fiscal channels – in effect diverting this amount from private health expenditure. Even within the current GOA expenditure level, however, GOA could subsidise 50% of the costs of private insurance for the whole eligible population. GOA direct subsidy to HAA would cease as the HAA, like other providers, would earn its income from insurance reimbursement and patient co-payments.

One potential disadvantage of diverting expenditure through insurers is their weak ability to use spending to drive quality improvements and cost containment, particularly in the creative funding of prevention. Insurers tend to be re-active through reimbursement rather than pro-active through contracting. It is conceivable that, with the annual insurance contract being awarded by the NHF, arrangements could be made through insurers to reward successful prevention as part of insurance contract tendering. But with such active engagement by the NHF, the benefits of going the insurance route are then being reduced and it may be better for the NHF to negotiate and contract directly with providers.

NHF capital fund

Prices negotiated with providers should allow for depreciation and capital investment without further capital allowances for the HAA. Whilst this is already the case for the private sector, it is not for the HAA. Consideration could be given to a one-off capital payment to the HAA if it becomes independent, after which it will be expected to reflect depreciation in the rates it charges NHF. This capital payment could be for a combination of additional equipment needed to update key services and essential backlog repairs. Nevertheless, the NHF might consider maintaining a small capital fund offering loans at preferential rates to providers on Anguilla with which to raise their diagnostic and treatment capacity in areas judged by

NHF as being desirable. This might also be used to buy a consumer health education programme focused on the prevention of chronic conditions.

Recommended option for the NHF

It is recommended that the NHF should operate much as originally designed, run by an experienced medical purchaser as Chief Executive who may also assist with medical advice to the MOHSD. This is to ensure that it acts exclusively in the interests of consumers and specifically that it is focused on paying providers for preventive services. Further, it is recommended that the NHF Act be changed to shift board member appointments from ministers to representatives of commerce, industry and consumers.
The conventional insurance option is not recommended because it is expensive and cannot deal with prevention adequately (see Annex 4 for a discussion of the advantages and disadvantages of an insurance-based system).

A suitable medical manager as Chief Executive (CE) could also assist MOHSD with a number of health policy and medical issues – a skill that is missed currently in the absence of a CMO. This will avoid duplication and shift some of the MOHSD workload to the NHF able to respond quickly and with common interests of public health and disease prevention. An external agency or an insurance company could not do this. A medical CE under contract to NHF may be an expensive position to fill (at international rates), but against the cost efficiencies that will be achieved, this will be a small price to pay, and still a fraction of the cost of an insurance-based system.

It is recognised, however, that the role of NHF is quite difficult technically, and the NHF Board will need some support. A very practical option to get things started would be to appoint a health management company for a period of 18 months to directly run the NHF during the transition period. Part of its brief would be to find a suitable Chief Executive to take over. At the same time, the health management company could support the transition and management of the new health company formed from the HAA. Draft terms of reference are provided at Annex 5.

2.1.3 GOA's role in the health system

The key role for MOHSD is to ensure that the 'big picture' is being achieved and that consumers are getting quality and value for money services from the arrangements in place. Much of the MOHSD role can be delegated to NHF including, for example, development of a national emergency plan for health, public education and behaviour change programmes, and the generation and use of national health statistics. NHF will ensure that, where appropriate, tasks are included in provider contracts eg. the generation of health statistics.

2.2 Configuration of services and cost implications

What kind and level of services does Anguilla need? As mentioned earlier, the need has shifted dramatically to the prevention, early diagnosis and management of chronic conditions. This is not being done well currently as indicated by the frequency of advanced stage diagnosis, but adequate data for Anguilla is not available. International data suggest that less than half of diabetes cases are diagnosed and that less than half of these have glycated haemoglobin (HbA_{1c}) concentrations below 7% or 53 mmol/mol, the level at which diabetes is being well controlled. Moreover, other key measures may be even less well controlled including blood pressure and lipid concentrations, kidney function, and absolute cardiovascular risk – all-important biomarkers for people living with diabetes.

The growth in chronic conditions places an increasing burden on health and social services – a burden increasing absolutely, not just as a proportion of all ill health. Already, the HAA is spending the equivalent of 16.7% of its GOA allocation on dialysis, and this is set to spiral (see box). This is an emergency, and requires a rapid and revolutionary change in the way services are delivered and providers paid and incentivised.

Box on dialysis

Currently, HAA spends up to $2.8m per annum for dialysis for 12 people. Until and unless Anguilla can begin to reduce predisposing conditions – particularly diabetes itself predisposed to by diet, over weight and insufficient exercise - the demand for dialysis will rise relentlessly. The consequences of new risks for early onset of over weight in young people are not quantifiable but will doubtless accelerate the incidence of renal failure. The health care system must be built on primary care and public education measures to reduce these risk factors, but this is reducing future risk and will be unable to have a big impact in the very short term. To the extent that renal failure is preventable by personal lifestyle choices, it is undesirable to guarantee everyone dialysis anyway. We must have incentives to keep ourselves well.

Using crude international rates, and assuming Anguilla would be at the higher end of the range at about 1,000 per million population in need of treatment, we would expect there to be around 12-15 patients currently. In England, rates have been rising at 4.5-5.0% per year, but with Anguilla's ethnic make up, high rates of diabetes, vascular disease, hypertension and rapidly aging population, the rate of increase could be double this. For illustrative purposes, if we assume the increase is 10%, then 60 people will be in need of treatment 20 years from now assuming treatment is provided for those developing this need each year. Today, this would cost GOA 87% of its HAA allocation per annum, or 56% of GOA total expenditure on health. And it will take at least this amount of time for a relatively stable state to be reached in which the number of new patients starting dialysis equals the combined number leaving dialysis as transplanted patients or dying. This situation is little short of an emergency.

It emphasises first of all the importance of restructuring primary care including introducing financial incentives to care providers for prevention. Regular testing of patients with pre-diabetes and diabetes can give early indication of renal damage and allow early intervention to delay or even prevent progression to established renal failure. Contracting and payment to primary care providers must attack this really forcefully immediately, and combine it with focused consumer education.

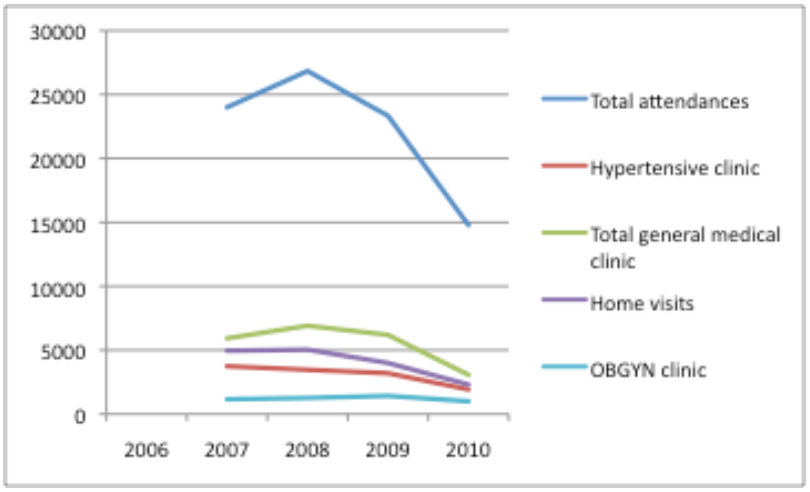
Second, although the costs of transplantation are about the same as for dialysis in the first year (for surgery, drugs, checks and any other treatment), they fall considerably in subsequent years making transplantation the most cost effective treatment, as well as that with the best quality-of-life outcome. It may become necessary to restrict public financing for dialysis to those patients assessed as suitable candidates for transplantation.

2.2.1 Primary care

HAA primary care attendances have been declining in recent years (Figure 1) as consumers have, presumably gone elsewhere in larger numbers. Assuming each consumer makes an average of 2.5 primary visits annually, the HAA share has declined from over 60% to under 40% of total visits between 2009 and 2010. Factors in this decline may include the quality of services possible at the smaller units, and the effects of economic recession.

It is primary care that holds the key to improving quality and containing costs for the care of chronic conditions. The design for the NHF is based on replacing the episodic treatment of illness with a system in which providers are incentivised to screen the population they are responsible for, and provide continuous risk reduction and management – and getting paid for doing so.

Figure 1: HAA PHC visits by total and by some components



Through its spending and contracting with primary care doctors, the NHF would be looking to encourage larger medical practices with the capacity to provide:

- continuity of care, including by practice nurses
- preventive services including
  - antenatal and postnatal care, family planning
  - child health services (0-9 years) including growth monitoring, immunisation and dental health
  - adolescent health including education on substance (including tobacco) abuse, and sexual health
  - screening and management programmes for priority conditions eg. hypertension, diabetes, cancer of cervix, breast, and prostate
  - obesity prevention and management
  - continual consumer education and behavioural change
- general diagnostic and curative care, including timely referral to specialists
- dental care, preventive and curative
- ophthalmology
- mental health
- foot care
- pharmacy service.

The better private doctors on Anguilla would be likely to respond to these incentives if they knew the NHF was well run and if their funding from NHF was predictable, allowing them to invest with confidence. An independent HAA would also have to respond by concentrating its services in order to provide acceptable quality and contain costs. Specifically, for example, consumers would benefit from a consolidation of all (five) HAA primary care units into one busy, well-staffed and well-equipped centre. This could have full-time medical cover. Patients would travel a bit further – this is not such a problem in Anguilla – but would have a much better service able to undertake a wider range of preventive, diagnostic and patient management services. This could genuinely be presented to consumers as a big step forward in service quality, not as a cost-cutting measure.

Table 2 illustrates the direction that HAA primary care might take under the influence of NHF pressure and with the ability of the HAA to act independently. The current five primary care units and dental services are centralised into one modern unit providing comprehensive primary care. It is not strictly a 'centralised versus decentralised' comparison because the centralised scenario presents services that are not now being provided, and shows a more idealised staff range and mix than is provided currently from the small dispersed units.

Table 2: centralised primary care

	Centralised PHC Unit			Current cost centres (total 5+dental units)				
	No.	unit cost	total cost					total cost
				East	Central	West	Dental	
Community Care Coordinator	1	113,042	113,042					-
Doctor	2	178,007	356,014	1	1	1		534,021
Community Nurse III	1	107,258	107,258	3	1			429,032
Community Nurse II	3	98,099	294,297	2	2	1		490,495
Dietetic Technician	1	107,599	107,599					-
Dentist	2	177,907	355,814				2	355,814
Dental Assistant	3	61,049	183,147				3	183,147
Senior Dental Therapist	3	82,315	246,945				3	246,945
Community Health Aide	3	74,854	224,562	4	3	4		823,394
Infection Control Officer	1	109,658	109,658					-
Coordinator Mental Health Nursing	1	101,699	101,699					-
Senior Health Educator	4	97,299	389,196					-
Registered Nurse/Midwife	2	104,999	209,998					-
Public Health/Environmental Health			-					-
Pharmacist	1	110,499	110,499					-
								-
Ancilliary staff	6	40,000	240,000	4	4	4	4	640,000
total cost			**3,149,728**					**3,702,848**

Note: Non-salary costs are not included here and, for comparison purposes, are assumed to be similar for each model.

Nevertheless, it indicates that a much-enhanced service could be provided for less than is spent now. Savings from medical, nursing and ancillary staff could fund a broader and more effective preventive and curative service including perhaps a transport service to improve access for those without personal transport. There would be savings too from time lost in travel by doctors, and from utility and maintenance costs. There would be benefits in the storage and handling of drugs and supplies, and in maintaining medical records.

HAA staff members are well aware of the advantages in quality and cost that would accrue from centralising primary care. They raise the issue that concentration to two rather than one centres would be a compromise position: one in the East and one in the West. A possible scenario under NHF funding pressures might well be for the new independent HAA to operate one primary care centre out of the polyclinic building (East), and for a joint practice of private doctors to operate one in the West.

Within an improved, centralised primary care service, an independent HAA might well find a number of specific cost saving opportunities, particularly if all staff were incentivised to be cost effective in every aspect of their work. Dental services, for example, have identified potential savings by ceasing to provide cast metal prosthesis, offering exclusively acrylic work. Savings from this and many similar small changes across primary care would depend on how the provider was paid for the service: what combination of fees from patients and contracted payment from the NHF was in effect. Pressure would also be on providers to seek lower input prices through more competitive tendering from suppliers.

2.2.2 Secondary care

Modern medical practice is squeezing the general hospital: more sophisticated diagnosis and treatment is being conducted in doctors' offices, and referrals are being made more to specialist centres bypassing general hospitals. In Anguilla's case, this means overseas.

Currently, the hospital provides general secondary care in medicine, surgery, paediatrics, and obstetrics and gynaecology, plus some psychiatric care. It is supported by X-ray, laboratory and pharmacy services. It

has 31 beds and operates at 30% occupancy, with extremes of 17-38% by month. It is staffed by 10 specialist physicians, and about 46 nursing staff (all levels including aides and orderlies), plus supporting technical and ancillary staff. Inpatient and outpatient workloads have declined over recent years (Figures 2, 3 and 4). Total salary and salary-related costs are around $18m for 2010.

Figure 2: PAH outpatient and casualty visits

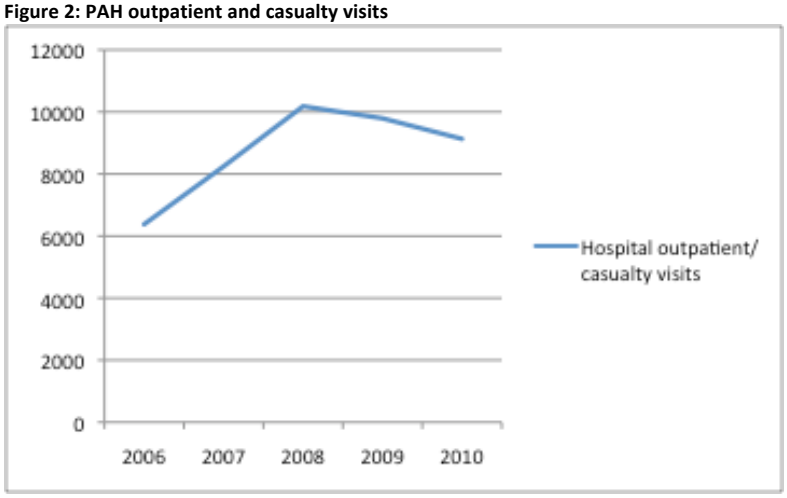


Figure 3: PAH inpatient admissions

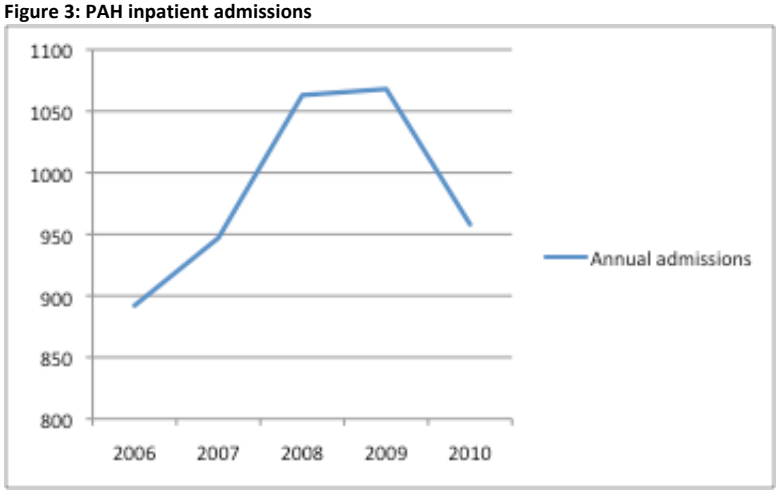
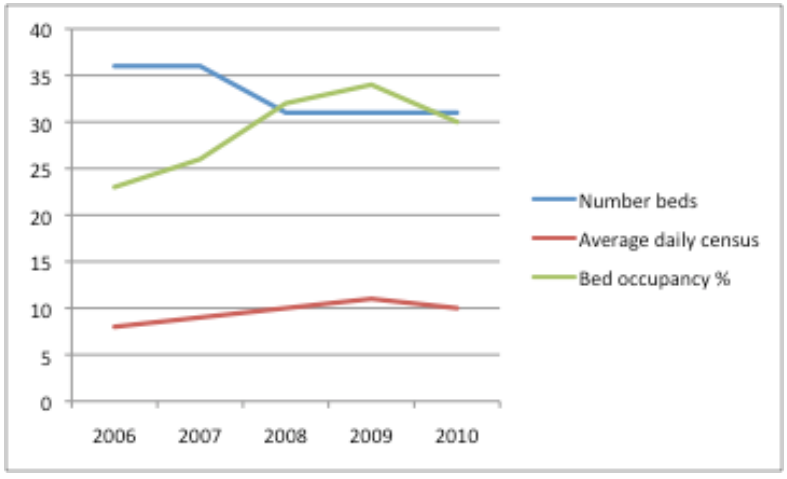


Figure 4: PAH beds, average patients per day, and occupancy rate



Box: a note on the Princess Alexandria Hospital

The low bed occupancy rate occurs because the hospital has too many beds not because it is under-utilised in terms of population needs for the services it currently offers. Indeed a detailed analysis some years ago found that there appeared to be too much inpatient activity suggesting there may be some inappropriate admissions - a common result when there are too many beds available and, therefore, little pressure to contain admissions.

The correct response to this is to reduce the bed numbers rather than to stimulate additional inappropriate admissions or over-long stays. The earlier detailed studies - undertaken when there were 36 beds - calculated that 19 acute beds would suffice, suggesting that a number in the low 20s at most would be appropriate today. This does not include the long stay beds in the MGMH (for senior citizens).

The introduction of new inpatient specialties would also increase bed utilisation, but this would be completely inappropriate since workloads in such specialties would not justify a full time medical appointment - the caseload likely to be generated in orthopaedics, for example, would keep an orthopaedic surgeon only 50% occupied. Already, the small population base cannot keep some of the hospital's technical staff fully and properly occupied. Whilst in some departments less than one full time member of staff could cover actual workloads, at least two people are required in practice to provide continuity of service.

A viable future for PAH depends on its ability to run a small, highly efficient hospital maximising diagnosis and treatment on an outpatient and day-case basis and keeping patients out of beds unless it is absolutely vital for them to be in one. Also, it may prove better in terms of quality and be more cost effective to send some patients overseas to centres of excellence for selected treatment eg some elective surgery. An independent PAH could take steps to reduce the number of beds it tries to operate and service, together with corresponding staff numbers. A smaller, leaner, busier and more productive hospital will result. Some small physical changes to the hospital may also assist in improving operational efficiency. A target for an independent PAH in reducing bed numbers could be to reduce salary costs by about 15%, saving $2.7m annually. It must be said, however, that estimating real savings resulting from bed closures is notoriously difficult, and depends on many factors including the eventual balance of fee income and annual contracted sum with NHF.

Another area in which PAH could reduce costs is in the accident and emergency service (A&E). Currently, the hospital operates a 24-hour service employing four full-time doctors plus supporting staff. This is four out of a total of 10 hospital doctors. In practice, a doctor is rarely needed for A&E events (major trauma and cardiac events are the main exceptions) most of which can be dealt with very effectively by well-trained nurses. It would be possible to reduce medical cover in terms of full-time employed doctors and institute a cell phone rota linking suitable off-duty doctors including private doctors. This might save upwards of $200,000 a year. This issue has a political history that will make rational decisions difficult but is another important example of where progress will be very difficult unless service providers are independent and under contract with a technical purchaser, free of political influence in operational level affairs.

Under NHF purchasing pressures, all providers will see advantages in rationalising rather than duplicating services although, taken too far, this could reduce potential competition between providers and end up offering the NHF less choice on Anguilla. This is not easy to manage, and the disadvantages and diseconomies inevitable in Anguilla's small population will always be present.

2.2.3 Tertiary care

Anguilla will always be dependent on overseas care for some specialities since it does not have the population to generate sufficient caseload to enable those services to operate safely and effectively on-island. Considerable worthwhile experience has been built up with a number of overseas centres to allow NHF to purchase services from them.

Initially, this will probably have to be on a case-by-case basis as now, but with contracted secondary care providers on Anguilla – and NHF - responsible for ensuring that only needs-based care and cost effective treatment are purchased. As more experience is gained, it may be possible to establish more cost effective arrangements with one or more providers, but efforts so far have not been able to do this.

The examples of changes at primary, secondary and tertiary care summarised in this section do not need to be dictated from GOA, and should not be. They would flow inevitably from the structure outlined above with the Fund pressuring for quality improvements and efficiencies, and the providers including HAA able to respond by running their own 'businesses'. In the immediate term, however, GOA would need to set up HAA as an independent organisation able to respond to NHF pressures.

3. Cost and revenue model

There are a number of ways of estimating the expenditure needed to obtain an acceptable coverage and quality of health services for the country, including:

- up-dating the detailed cost estimates made earlier
- adjusting what is being spent now for known inefficiencies
- projecting insurance based estimates

and incorporating estimates for possible efficiency savings and the changing nature of the needs for care.

Up-dating the detailed cost estimates made earlier

Very detailed, bottom-up cost estimates were made in 2001 and updated for inflation and other factors in 2007 [Anguilla National Health Fund: Manual of Intentions and Procedures, 14.06.2007]. For what these are worth now, inflating these costs to 2010 suggests costs of a reasonable health service would be at least $30m without including cost inflation from newer technologies and treatments (see Table 3).

Table 3: updating cost estimates for inflation

	2007	2008	2009	2010
population covered	12,500			13,000
up-date for inflation @ 3% pa	25,759,144	26,531,918	27,327,876	28,147,712
up-lift for population increase				29,178,078

These estimates were based on applying established satisfactory international staffing norms (and non-staff costs) for the service volumes in the different clinical specialties to be expected from the population structure at that time, and on the premise that services would be run efficiently, with informed demand and no excessive use, and with efficient transaction costs (including no insurers profit or claims processing costs). They were, therefore, a benchmark to be aimed for rather than a prediction of what was likely, the latter depending on the way in which the health system would in practice be structured and financed.

Adjusting what is being spent now for known inefficiencies

Although we know that much of the $54m spent annually (see Table 1) is not spent efficiently, it is not possible to quantify this very accurately. We could estimate that:

- HAA services could be improved and rationalised as outlined in section 2.2, and that this could save around $3-4m per annum

- much care sought overseas could be obtained on Anguilla for less, especially for primary and hospital outpatient care – if these were improved

- around $4m a year goes to insurers profits and transaction costs rather than health care (at an 80% loss ratio)

- much self referral by the uninsured is ill-informed and could be avoided or care obtained at less cost through knowledgeable single payer arrangements

- there may be a tendency for the insured to over-consult and over-consume, and this is reinforced by fee-for-service payment for providers in the private sector.

So perhaps $10m or more per annum of combined public and private expenditure could be saved if the health system were working more efficiently, giving a total cost of around $44m. This could be achieved with no diminution in quality – and sometimes with improved quality.

Projecting insurance based estimates

If the whole eligible population of around 12,300 were insured with private insurance at current rates of $341/month, this would cost $50.3m. If 20% of this is the insurers profit and overhead, then $40.3m would actually be spent on care, with an additional 20% of that amount spent by consumers in co-payments. So around $48.3m a year would buy a national health service to the standard now provided under private insurance (see Table 4). We know, however, that much of this is spent inefficiently as mentioned immediately above.

Table 4: costs of health care based on insurance costs

		2010
1	Total population	15,000
2	% Anguillian	70
3	Population Anguillians	10,500
4	Work permits	1,441
5	Work permit dependents (25%)	360
6	Total elligile population	12,301
7	Private insurance premium per person per month	341
8	Total premiums per annum	50,336,715
9	% spent on care	80
10	Expenditure on care	40,269,372
11	Co-payment %	20
12	Co-payment $	8,053,874
13	**Total expenditure on care** (rows 10 + 12)	**48,323,246**

Costs with NHF as purchaser of services

In summary, it should be possible to purchase a decent and appropriate national health service for all 12,300 eligible Anguillians and legal expatriate workers for around $40-45m a year at 2010 prices, if that money was being spent efficiently. This excludes insurers profits and other transaction costs of a system based on insurance.

Costs with NHF as purchaser of insurance

With an insurance-based system, the total cost to NHF will be more like $50.3m a year on top of which consumers will pay $10.1m a year in co-payments, so total national health expenditure will be $60.4m a year (see Table 5).

Table 5: costs of health care with NHF as purchaser of insurance

		2010
1	Total population	15,000
2	% Anguillian	70
3	Population Anguillians	10,500
4	Work permits	1,441
5	Work permit dependents	360
6	Total elligile population	12,301
7	Private insurance premium per person per month	341
8	Total premiums per annum	50,336,715
9	Co-payment % of expenditure on care	20
10	Costs of co-payment	10,067,343
11	**Total national expenditure on care** (rows 8 + 10)	**60,404,058**

Summary

Table 6 shows a provisional model of estimated revenues and expenditures as if the health system were in a steady state in 2010 using a target of $42.5m a year as the costs of services for the 12,300 eligible population. It indicates that this could be funded with GOA expenditure at $25m per annum transferred to the NHF, with a 6% levy on insurable earnings, and with consumer co-payments in line with the original assumptions for the NHF (much less than the 20% co-payment under insurance). This is based on efficient direct purchasing by NHF, and NHF administrative costs of $0.6m a year. The table shows a small deficit but this is well within the limits of accuracy of the assumptions made, and can be eliminated with marginally different co-payments for example. The point is to illustrate the general feasibility of the system. Note that in practice, GOA will be paying the employers 3% health levy for civil servants, as well as providing an annual subvention to NHF. It will cease paying the civil servants health insurance currently costing $4.6m annually (Table 1). The $25m includes estimates of the cost to GOA of the 3% levy and represents the best estimate at this time of total GOA financial obligations to health apart from MOHSD salaries and costs as now.

Cost control will be an integral part of the NHF work. Various ‘levers’ are available to NHF. Excessive demand for primary care can be dampened if necessary by increasing consumer co-payments to service providers. Excessive overseas tertiary care costs can be contained by NHF not approving referral for expensive cases with poor prognosis. Ultimately, control can be exercised by withdrawing specific medical conditions from NHF coverage.

Table 6: Cost and revenue model 2010

Assumptions:					
insurable earnings 2010	263,779,364	EC$ [SSB figure 2011]			
NHF contribution from income	6.00	%			
co-payments - primary	25	EC$ per visit (NB. $10 for over 65 not factored here)			
primary care visits	2.50	per capita per annum			
primary care visits	30,750	total for HAA, private and SXM			
co-payments - secondary	-	EC$			
co-payments - tertiary	5.00	% of total costs			
population covered	12,300	15,000 Anguillans; 1440 work permits + 360 dependents			
co-payment for drugs - primary	10	EC$/item			
prescriptions rate - primary	2.50	items per capita per annum			
number of prescriptions - primary	30,750	total per annum			
co-payment for dental care	25.00	EC$ per visit			
dental visits	1.00	per capita per annum			
dental visits	12,300	total			
Funding by source:			**Income to NHF**	**Patient pays provider**	**Total funding for health care EC$**
GOA subvention			25,000,000	-	25,000,000
earnings contribution			15,826,762	-	15,826,762
co-payments - primary			-	768,750	768,750
co-payments - secondary			-	-	-
co-payments - tertiary			643,875		643,875
co-payment for drugs - primary			-	307,500	307,500
co-payment - dental			-	307,500	307,500
Totals			**41,470,637**	**1,383,750**	**42,854,387**
Estimated costs of health care:			**Paid by NHF**	**Paid by patient to provider**	**Total costs EC$**
clinical primary care			5,606,250	768,750	6,375,000
drugs - primary care			1,265,000	307,500	1,572,500
dental			1,265,000	307,500	1,572,500
community psychiatry			425,000		425,000
public health			1,445,000		1,445,000
secondary care			18,232,500		18,232,500
teriary care (mostly overseas)			12,877,500		12,877,500
sub-total			41,116,250	1,383,750	42,500,000
NHF operational costs			600,000		600,000
Total			**41,716,250**	**1,383,750**	**43,100,000**
Estimated surplus (deficit):			- 245,613	-	- 245,613
Health expenditure per capita (12,300 population covered)				EC$	3,504
				US$	1,298

4. Action programme and implementation costs

The broad stages of implementation are shown in Figure 5. These are timed around the target of January 2013 when GOA will transfer the 6% health levy to the NHF. It allows for a health management company to be in place for a period of 6 months prior to this, and six months after to begin operations and hand over to appointed key staff.

Figure 5: broad stages of implementation

year	2011	2012				2013			
quarter	4	1	2	3	4	1	2	3	4
Broad stages									
Aprove Review strategy									
Appoint health management company									
health management company support									
Establish new HAA company									
operate new HAA company									
Develop NHF systems									
operate NHF									
Appoint key long-term staff									
Transfer GOA helth budget to NHF						*			
Transfer 6% levy to NHF						*			

The key actions and activities to be undertaken are the following.

Establishing the new HAA company

- Set up a small HAA 'Senior Management Change Committee' (subsequently, members will form the Managing Board of Directors of the new company) to work with the contracted health management company
- Committee to begin planning the rationalisation of services – this will later be supported by the appointed health management company
- Communications programme with all HAA staff to explain what is happening
- Suspend the Board of the HAA pending repeal of the HAA Act
- Select a new name for the company reflecting its private status
- Prepare the company's rules and *modus operandi* including Articles and Memorandum
- Form and register the legal company (with local legal and accounting assistance) including a trust to hold the unallocated shares (see Annex 3 for details) and decide number of shares and basis for allocation
- Work with local legal and HRM assistance to transfer HAA staff from statutory authority to company employment contracts, and allocate shares
- Repeal the HAA Act
- Implement programme to introduce new systems for HRM and financial control
- Design and manage the implementation programme to improve services quality, training, medical records and data systems
    - Centralise primary care to one or two comprehensive health centres and get up and running
    - Incrementally rationalise bed numbers and inpatients admissions policies
    - Establish registration system for patients
    - Establish chronic disease registers
    - Identify and prioritise short-term training needs and provide these

- etc

- Specify, search and appoint a long-term Chief Executive (probably international) and a Finance Director (probably local from commercial sector) to work with the health management company until handover

- Seek international charitable support in terms of a relationship with a large overseas hospital (probably in North America) funding training, staff exchanges etc

- Maintain GOA subvention directly to HAA until NHF systems working

Setting up NHF operations

- Hold consultations with private providers on Anguilla (private doctors and new HAA company) to explain concepts and preferences for services, and to assess which providers will participate

- Finalise and set up systems for contracting providers
  - Interim arrangements to get started
  - Next-stage payment mechanisms to include payment for specified preventive activities
  - Registration of consumers with providers – patient register
  - Rules and mechanisms for referral
  - Mechanisms for medical records etc

[Note that arrangements for these systems are outlined in the NHF Manual of Intentions and Procedures, but these will be refined in practice.]

- Communications with the public to explain what is happening including registration for NHF through SSB, and registration with primary care provider.

- Make NHF estimates for costs of different services with which to negotiate with providers and prepare more detailed budget

- Select overseas care providers and negotiate best prices and mechanisms – this may mean continuing with some current overseas providers at least initially

- Appoint SSB and work with it to register eligibles

[Note that arrangements for these systems are outlined in the NHF Manual of Intentions and Procedures, but these will be refined in practice.]

- Set up banking arrangements to receive monthly payments from GOA and from the 6% health contributions from income

[Note that the 6% on insurable earnings will be collected by SSB in parallel with SSB contributions but directed to the NHF bank account.

- Begin to receive income from January 2013 and pay participating providers

- Contract a medical director for NHF to take charge of implementation in the longer term

Costs

Costs are based on appointing an international health management company providing the equivalent of two full time experts for a period of 12 months plus all travel and associated expenses. In practice, the company would provide an anchor person more or less full time resident in Anguilla, with other intermittent inputs from experts as needed and agreed, supplied by the company. The majority of this

intermittent support would be from a hospital manager to direct the HAA change process and operations under the new company structure. Input would reduce as key long-term staff members were appointed to the HAA and NHF. Other short-term inputs might include expertise in primary care prevention and related provider payment mechanisms based on registration and regular management of patients (to detect and manage all pre-diabetics, for example).

Total costs over the 12 months would be up to US$400,000. After January 2013, costs would be partly paid from the NHF budget as GOA and the 6% levy transfer to the NHF. So the up-front additional costs would be around US$200,000-250,000 in 2012. These costs must be seen against the cost reductions possible by capping GOA health expenditure at $25m (2010 prices) and the short-term savings in HAA operational costs achievable as outlined in this Review. It can also be noted that currently, GOA is paying US$340,000 a year to an insurance company for transaction costs and profit for the civil service health insurance.

Annex 1: data and assumptions used in Table 1

		GOA CS insurance
1130		average number of CS covered by GOA CS insurance (NAGICO) in 2010 (derived from total GOA expenditure/341*12) NB. DPA figure is 1020
341		cost to GOV per insured per month
78		average expenditure by insured on family cover per month (derived from total exper
0.23		average number of dependents insured (@$341 per insured) per pr NB. This is minimum since child cover is only $65
		Statutory Authority insurance
360		number of SA employees insured (all cpmpanies)
341		cost to SA employer per insured per month (assumed same as CS)
78		average expenditure by SA insured on family cover per month (assumed same as CS)
		Private insurance
2020		number of private employees insured
341		cost to private employer per insured per month (assumed same as
78		average expenditure by insured on family cover per month (assumed same as CS)
		Individual 100% self pay insureds
490		number of insured
341		cost to insured per month
78		average expenditure by insured on family cover per month (assumed higher than for
80%		**Insurance loss ratio** total payments as % of total income from premiums
4,000		**number of principal insureds**
0.23		**insured dependents per principal insured**
33		**% of population insured** NB. This is minimum number
		Distribution of expenditure through insurance %
12.50		HAA PAH
12.50		HAA primary care
50.00		private on Anguilla
25.00		overseas
		Out of pocket expenditure at HAA
8,528,800		total fees revenue to HAA
5,734,568		fees paid by uninsured (100%)
2,235,385		fees paid by insurance companies
558,846		co-payment by insured (20%)
		Distribution of expenditure within HAA
80%		PAH
20%		PHC/community
0%		MGMH
		Primary care consultations:
25%		HAA share
50%		private doctors Anguilla share
25%		overseas inc St Martin, P Rico share
2.5		average consultations per person per year
200		average consultation fee for private doctor on Anguilla
50		average drugs spend per consultation for uninsured on Anguilla
10		average drugs spend per consultation for insured @ 20% on Anguill
300		average consultation fee for private doctor St Martin / overseas
100		average drugs spend per consultation overseas for uninsured
20		average drugs spend per consultation for insured @ 20% overseas
		Referral care overseas
1664		number of visits to overseas specialist care: 10 private and 6 HAA doctors referring 2 patients pe
5000		average expenditure per visit

Table 1: Notes to row numbers:

1	eligibles: 10,500 Anguillans, 1,441 work permits, 360 work permit dependents
2	GOA Estimates 2011: budget figure for 2010 or HAA accounts actuals 2010
3	Average over 2006-2010 as large fluctuations by year
4	Figure for 2010
5	Average over 2006-2010 as large fluctuations by year
6,7,8	from Department of Social Development Annual Report 2011
9	MOF data for established and unestablished posts
9, 11-17	allocations to providers are less than total expenditure on premiums to allow for insurers' loss ratio
11	survey of SAs under AHSR 2011
12	survey of SAs under AHSR 2011
13	survey of insurers under AHSR 2011
14	survey of main employers under AHSR 2011
15	MOF data for established and unestablished posts
16	estimate from insurers data
17	estimate from insurers data
20	HAA fees data allocated to uninsured in proportion
21	HAA fees data allocated to insured in proportion
22	estimated as 200% of HAA fees
23	estimated as 200% of HAA fees

Annex 2: HAA – an organisational self-diagnosis

Senior management of the HAA recognises a number of weaknesses and problems with the performance of the organisation and how consumers of services perceive it. They also identify a number of what they see as root causes of these problems. These include the following.

The HAA relationship with GOA is problematic. Managers feel that they cannot make or implement some hard decisions because GOA will intervene if any such decisions may be unpopular with the public. Yet at the same time, they are under pressure from GOA to improve and save money.

Overall management has seen problems, and there has been a lack of appropriate and dynamic leadership that led to de-motivation within staff that the HAA has yet to recover from.

The role of the HAA has not been defined clearly enough, and the absence of a strategic plan for the organisation means that there are no real guidelines for the organisation or parameters against which to measure performance. The issue of possible re-entry into the public service has had a further destabilising effect, and although this now appears to have been decided against, the lack of clear structure and role for the HAA persists.

Partly as a result of the above, the organisation is running day-to-day, fire fighting, without a clear vision or strategy to achieve it. The target of accreditation (from Canada) adopted in the early days provided a good discipline for everyone to work within, although it required considerable paperwork and time. But this has now been abandoned.

Financing uncertainties are not helpful, and the HAA is caught in the middle. Consumers still expect health care to be free and little has been done to educate them that it is not, yet the HAA must charge fees to survive – and is encouraged by GOA to collect more. It is difficult to run any organisation when funding is unpredictable year-on-year. The HAA has responded as well as it can to the 25% budget cut but this may just mean there are more creditors at the end of the year.

There is a high turnover of staff, and many of the non-nationals are less caring – a factor made worse by the demoralised context at the moment.

Reviewer's comments

This is a very positive self-diagnosis. The HAA has some talented and committed staff but the organisation has suffered de-motivation of late resulting from several causes but primarily the feeling that management is not really in charge of the organisation, and that hard but needed decisions will be frustrated at the political level.

The senior management appears ready for change and challenge. There is a very positive reception to ideas for more and proper independence of structure and operation.

The organisation needs an experienced general manager able to lead it through the required reforms, introducing output-based budgeting and accounting, job descriptions linking individual to corporate goals, and incentives for performance.

Annex 3: transforming HAA into a company owned by staff

Accumulating evidence indicates that staff ownership and participation in businesses delivers superior performance. Staff members are more committed to the company because they are rewarded for performance, and decision-making tends to be more inclusive and seeks innovation.
http://www.employeeownership.co.uk/employee-ownership/the-evidence/

This annex provides notes on some of the issues that will have to be considered during setting up of the company.

What we want to achieve

We want to form a healthcare provider organisation with built-in incentives to perform efficiently, responding to quality standards required by an independent purchaser (from which the company will earn most of its income), and to the needs and preferences of consumers. To achieve this we propose to incorporate a limited liability company owned by its staff: all staff will own shares and have voting rights. The assets of the Health Authority of Anguilla (HAA) will be vested in the new company and the HAA legislation repealed.

The Company

A limited liability company will be formed and shares issued and allocated to staff. The shares cannot be sold to anyone except back to the company when a staff member leaves the company. Staff members receive a dividend per share (or bonus equivalent) annually based on the preceding year company profits. This also sets the value of the shares for the following year – the value used if shares are sold back to the company.

The company will have a turnover of around $25m (US$9.25m). As a Statutory Authority now, it employs around 200 staff.

In practice it is likely that these objectives can be achieved most efficiently by the creation of an employee trust owning the shares on behalf of staff. The trust will be legally obligated to apply the benefits of the shares to employees as if they actually owned them individually. This allows the trust to maintain a 'warehouse' of unallocated shares through which to build up a capital reserve with which to buy back shares from departing staff. A trust avoids the complications and paperwork of actually issuing shares to each staff member and buying them back, and is legally quick to set up.

Other issues that would have to be addressed in forming the company include:

How to value the shares each year
This is needed both for purposes of paying annual staff bonuses and for buying back shares of departing staff. Whilst the 'value' of shares is normally determined by what they will sell for in an open market, that does not apply here. Valuation should be based on a simple transparent formula probably based on profits after capital investment reflected in the net value of assets over liabilities. These must be defined. It should ignore intangibles like goodwill or future prospects.

How to allocate shares to staff
Allocation is likely to be best based on seniority and salary in the first place (and subsequently). It is also necessary to decide how many shares are needed to maintain a 'warehouse' of shares to give to new staff.

How to achieve and maintain a cash reserve
The trust must accumulate a fund with which to be able to buy back shares from departing staff, although this can be cushioned by payback rules spreading payment over a number of years.

Tax issues
There do not appear to be tax issues in Anguilla that would distort sensible ways of shareholding – there is no personal or corporate taxation – but this will need to be checked during implementation.

What happens if there are losses rather than profits?
First no dividends are paid to staff. Second, the company has the freedom to negotiate with its main purchaser (the NHF) if it can show that payment rates cannot reasonably cover the costs of the services provided as agreed and contracted. This could result in increased payments or reductions in services for the following year and, *in extremis* could result in a retrospective payment. Third, the company can raise its fees for individuals not covered by NHF: mainly non-nationals not on work permits. Forth, the company can borrow from a commercial bank to cover a period until it can balance its budget. This illustrates and emphasises the importance of the company having an internal finance director with commercial experience.

2. Governance

Managing Board of Directors

The company will be run by a managing board of directors, and will not have a non-executive board in the way the HAA has now. The managing board of directors convenes on a routine basis to discuss the business: how the business is currently being run, what can be done to improve operations, and the future outlook for the business and the context the business is operating in. In terms of the day-to-day operation of the business, the managing board reviews policy and procedure for all aspects of the business, looking at budget, staffing, operations, and processes. Over the longer term, the board is concerned with developing strategy and business plans requiring incremental change in policy and practice.

The managing board of directors is made up of individuals representing key aspects of total business management and, in this case will probably best comprise mostly key employees of the company itself. It could comprise, for example:

Chairperson:
There are benefits in appointing an external (non-staff) individual with a good all-round background in commerce or industry to fill this role. It is a paid position (part time), and the individual is expected to bring experience and connections in business development and management.

Chief Executive:
This is a full-time staff member with good general management experience in the health field, probably as a hospital manager or similar. S/he must have leadership qualities, and good communications skills with staff and the public.

Finance Director:
This requires a full-time staff member with good commercial company finance experience. His function in the company is to develop and maintain a commercial accounting system providing management with up-to-date information on the operations and financial position of the company.

Human Resources Director
Medical Director

Nursing Director

To maintain an odd number of voting Directors, one of the above would not have voting rights at Board Meetings, but would attend in an advisory capacity. This could be the Finance Director. Alternatively, the Chairperson could have the casting vote.

The first Managing Board of Directors will be appointed during the setting up of the company. Subsequently, the Board itself takes decisions on hiring and firing of staff including Board members. Specified major decisions could require voting by all staff.

Annex 4: NHF as purchaser of insurance

The essence of this arrangement would include the following.

- All employers and the self-employed (as defined and registered with SSB) would be required by law to purchase health insurance for all staff and themselves, and all dependents. Arrangements could vary about what percentage is paid by employer and what percentage by employee.

- NHF would define the minimum health insurance benefits package and negotiate the annual price for this with an insurer selected by competitive bidding. NHF would also approve the insurers preferred providers especially those for overseas care. Individuals could pay extra for a more extensive policy if they wished.

- GOA would redirect its annual expenditure on health – currently around $26m although it has been more like $30m for some years – to the NHF which would use this to subsidise the annual price of the insurance obtainable from the insurer. The costs of insurance for employers, employees and the self-employed (covering a total of 12,300 individuals) would thus fall from around $307/month (assuming a 10% discount to current price of $341/month/person for the GOA plan) to $137/month/person. Without a 10% discount for volume, premiums would be $172/month/person.

- NHF would pay the premiums of those registered with the Department of Social development as indigent.

- The independent HAA and all other providers would earn their income from the insurer (80%) and the consumer (20% co-payment). Consumers would select their provider, and providers would set their prices to attract consumers.

- GOA would not need to introduce the 5-6% health levy on earnings as originally planned for the NHF to cover the costs of care if bought directly from providers, and would cease the civil servants insurance plan – but would need to continue to find $25m a year from the Consolidated Fund.

- Alternatively, GOA could charge the 5-6% health levy on earnings raising about $15m and provide free health insurance to all 12,300 eligibles – the gap of $5m would be covered with some changes to the co-payments planned.

Advantages

- The population understands the concept of health insurance and would probably like the idea – subject to some reservations noted below.

- It would be relatively quick to implement in the first place, and relatively simple to run, and would keep the functions and costs of the NHF to a minimum.

- It would attract new regional or international insurers into Anguilla who might specialise in health, and who might have a preferred provider network at competitive prices. And it might bring pressure on all competing insurers to innovate.

Disadvantages

- How equitable would this be? It replaces a percentage GOA take on incomes (the more you earn the more you pay into the Fund) with finance from general revenues. For some, the direct cost of insurance could be excessive, and why should the Consolidated Fund revenues be used to subsidise insurance for the better off?

- Could the smaller employers afford this? Would some employers put all the cost on employees instead of sharing it? The costs of the tourism product would rise as employers had to cover all staff and dependents (even if employees pay a large component this is still exerting upward pressure on wages).

- How to account for dependents – if employees had to contribute they would quickly prefer single employees! If individuals were responsible for covering all their dependents, this would be complicated to administer, and prohibitive to some families.

- The current premiums for the GOA plan are $341/month for the principal insured. But these people are all of working age and relatively low users of health care compared with the elderly and children. What would the premiums have to be to cover the increase in utilisation of care?

- A significant proportion of the premiums paid – around 20% assuming an 80% loss ratio for health insurance – is not spent on health care but on insurers profit and transaction costs.

- This would be a fee-for-service system that most of the world is trying to avoid or get away from. It encourages provider-driven over-consumption of services, and higher costs that insurers must pass on in premiums.

- How would this work for funding A&E? What would happen about dialysis and any other expensive long-term care? What would happen to those with pre-existing conditions?

- Some people would want to select their own package but still take advantage of the GOA subsidy. This will impose a burden on NHF to ensure that plans conform with at least the minimum.

- Perhaps the biggest potential disadvantage of all would be how to handle the serious prevention programme that Anguilla needs. How can insurance reward providers for prevention and keeping people well thus reducing their own income from curative fee-for-service payment? Replacing fee-for-service with registration of consumers with their choice of provider was a fundamental plank of the NHF concept.

- Introduction of universal insurance cover would likely result in a big and instant rise in utilisation of services. How could that be controlled?

Annex 5: TORs for health management company

The National Health Fund (NHF) wishes to appoint an experienced health management company to lead development and initial operations of the national health Fund (NHF) and, simultaneously lead the transformation of the Health Authority of Anguilla (NAA) from a Statutory Authority to a private company owned by staff, and support development of new management systems.

The NHF is being established as the national purchaser organisation for health care for all citizens. It is a hybrid national health insurance organisation funded by payroll deductions and an annual subvention from the Government of Anguilla (Consolidated Fund). The NHF will purchase care for the 11,500 eligible population of Anguillian nationals, expatriates on work permits and their dependents. Primary and secondary health services are to be purchased from providers on Anguilla, and tertiary services from providers overseas. Currently, there are some 10 private doctors and a further 10 doctors working for the HAA, the latter operating 32 beds and five community health units, and with a total staff of around 200.

Purchasing by the NHF aims to attack Anguilla's serious chronic disease burden by encouraging prevention, early detection and management. Payment will shift from a fee-for-service system to a per capita system under which providers are responsible for all patients registered with them and will be paid for specified preventive activities.

The NHF has been established by legislation and board members have been appointed. A health management company is now sought to work with and on behalf of the NHF Board to get operating systems up and running and to appoint key managers for the long term. In parallel, the health management company will direct the formation of the HAA as a company owned by its staff, and will work alongside the new company effectively in the role of Chief Executive working to improve performance to meet NHF purchaser requirements, and appointing key managers for the long-term continuation of operations.

Key tasks

The key actions and activities to be undertaken include the following.

Establishing the new HAA company and improving its performance

- Work with the HAA to set up a small HAA 'Senior Management Change Committee' (subsequently, members will form the Managing Board of Directors of the new company) and take over temporary leadership acting as Chief Executive.

- Plan and begin to implement the rationalisation of services (see examples below).

- Ensure that an in-house communications programme is provided explaining the objectives and mechanisms of the change process to all HAA staff, and that concerns are heard and dealt with.

- At the appropriate time, advise GOA to suspend the Board of the HAA pending repeal of the HAA Act.

- Select a new name for the company reflecting its independent status (not including "Authority" and probably not "Anguilla"). This might be done involving staff in a small competition.

- Prepare the company's rules and *modus operandi* including Articles and Memorandum.

- Work with local legal and accounting inputs to form and register the legal company, probably as a trust holding shares on behalf of staff and a 'warehouse' of unallocated shares – a separate document is available outlining the intensions and likely mechanisms for this.

- Decide the number of shares, the basis for allocation (they will be distributed free to staff in proportion to seniority in the company as they transfer employment from the HAA), and the formula for annual valuation of those shares as the basis for annual bonus (dividend) payments to staff and for buying back shares of staff leaving the company – the separate document provides more detail.

- Work with local legal and HRM assistance to transfer HAA staff from statutory authority to company employment contracts, and allocate shares.

- Advise GOA on the repeal of the HAA Act.

- Design and introduce new systems for HRM and financial control reflecting the new structure of the company. Financial systems, for example, will need to move from government accounting to commercial accounting able to relate inputs to outputs, and provide the Managing Board of Directors with financial information for planning and management. HRM will need to move to a transparent system of performance assessment for staff linking individual performance to overall business objectives and performance of the company.

- Design and manage the implementation programme to improve services quality, training, medical records and data systems, including:

    - Centralise primary care to one or two comprehensive health centres and get these up and running. Oversee communications with the public to explain the quality benefits.
    - Incrementally rationalise bed numbers and inpatients admissions policies in the Princess Alexandra Hospital.
    - Establish a primary care registration system for patients.
    - Establish chronic disease registers within primary care services.
    - Identify and prioritise short-term training needs and provide these.
    - etc

- Design a system to monitor and evaluate the results of key aspects of the changes introduced ensuring that relevant baseline data is recorded. This should cover practical input and output level indicators of system performance to inform on-going policy and management decisions (rather than pure research).

- Specify, source and appoint a long-term Chief Executive (probably international) and a Finance Director (probably local from the commercial sector) to work with the health management company until handover.

- Seek international charitable support in terms of a relationship with a large overseas hospital (probably in North America) supporting training, staff exchanges etc.

- The annual GOA subvention will continue directly to the new HAA company until NHF systems are working, at which point the GOA subvention will shift to the NHF to buy services.

Setting up NHF operations

- Hold consultations with private providers on Anguilla (private doctors and new HAA company being formed) to explain concepts and preferences for services, and to assess which providers will participate. A more detailed *Manual of Intentions and Procedures* has been prepared to guide and assist in this.

- Design a system to monitor and evaluate the results of key aspects of the changes introduced ensuring that relevant baseline data is recorded. This should cover practical input and output level

indicators of system performance to inform on-going policy and management decisions (rather than pure research).

- Finalise and set up systems for contracting providers including:

    - Interim arrangements to get started – paying participating providers interim payments until patient registers are operational.
    - Next-stage payment mechanisms to include per capita payment to providers for patients registered with them.
    - Payment arrangements for specified preventive activities.
    - Rules and mechanisms for referral – from primary care to secondary and from secondary to off-island specialist care.
    - Mechanisms for medical records etc

[Note that arrangements for these systems are outlined in the NHF *Manual of Intentions and Procedures*, but these will be refined in practice.]

- Communications with the public to explain what is happening including how eligibles should register for NHF through the Social Security Board (SSB) mechanism, and how they can register with a primary care provider.

- Prepare NHF estimates for the costs of different services with which to negotiate with providers and prepare a more detailed budget.

- Select overseas care providers and negotiate best prices and mechanisms – this may mean continuing with some current overseas providers at least initially.

- Appoint SSB and work with it to register eligibles.

[Note that arrangements for these systems are outlined in the NHF *Manual of Intentions and Procedures*, but these will be refined in practice.]

- Set up banking arrangements to receive monthly payments from GOA and from the 6% health contributions from income

[Note that the 6% on insurable earnings will be collected by SSB in parallel with social security contributions but directed to the NHF bank account.]

- Begin to receive that income from January 2013 and pay participating providers.

- Specify, source and appoint§ a Chief Executive for NHF to take charge of implementation in the longer term.

Duration

It is anticipated that the health management company will be engaged for a period of 12 months prior to full hand over to contracted longer-term key staff, extendable to 18 months subject to performance.

Input

It is anticipated that the contracted health management company will need to provide an anchor person in Anguilla full time (or almost full time) to lead this work. S/he must be able to call upon a range of other skills to support specific activities, equivalent to another full time person at least. These skills must include hospital management experience in independent hospitals, and medical purchasing *ie*. spending public finance to buy the best value-for-money health care services from a range of offering providers.