



FALKLAND ISLANDS GOVERNMENT

**GREEN PAPER ON HEALTH
CARE FUNDING**

MARCH 2009

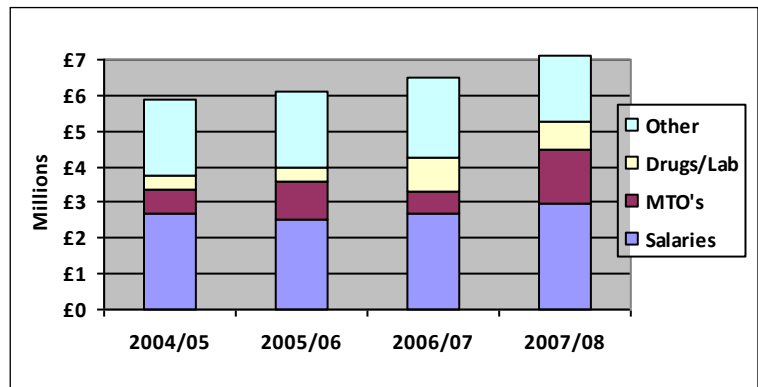
Introduction

1. As highlighted in the ‘Green Paper on the Budget’ we need to reassess our expenditure and service provision across the whole of government. This paper outlines some options for the future funding of health and social services. During the recent period of economic prosperity, residents of the Falkland Islands have basically enjoyed free healthcare. There are some charges for elective referrals, optician’s services and some dental services but all other services are provided free.
2. It should be stressed that we are not considering making the service totally pay for itself. To do that would be the equivalent of doubling tax levels. Instead, we are looking at ways of recovering some of the costs from the users (or potential users) of the health service. In the past, part of the health service was financed from a universal Medical Services Levy (MSL). The advent of fishing licence income allowed us to abolish MSL but falling receipts of fishing licence income have recently been the trend.

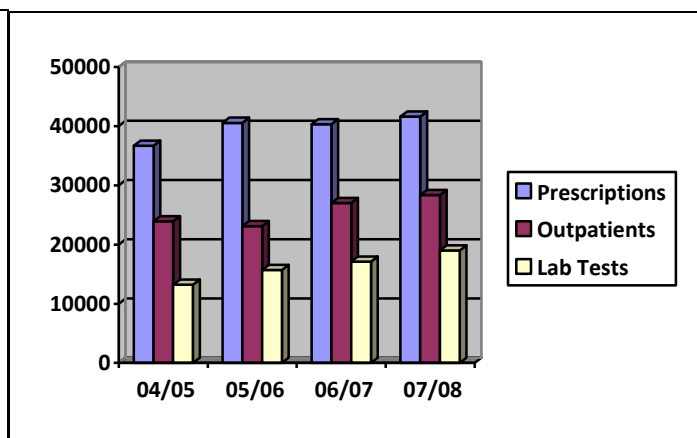
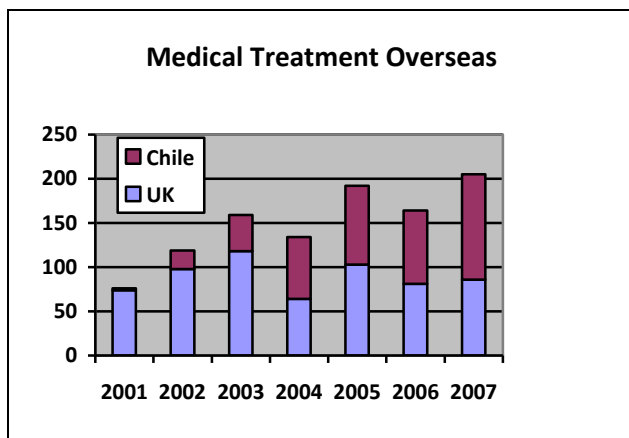
Background

3. The health and well-being of the Falkland Islands is a priority for Government. This has been demonstrated by the investment in facilities, equipment, expertise, choice and staff over many years. Unlike many other countries, we do not have lengthy waiting lists, divisions between primary and secondary care or protracted timescales for test results, and we often have the option of diagnosis and treatment in the UK or Chile.

4. As this chart shows, the costs of healthcare have been increasing over the last few years. This partly reflects the increase in staffing costs but also the burden of increasing referrals for medical treatment overseas (MTO’s). Increases in drug costs and laboratory costs are also significant as diagnosis and treatment becomes more sophisticated.



5. The increase in expenditure reflects the growing demand and expectations on the health service. The following graphs show the increases in the numbers involved on the main patient-based areas:



Funding Options

6. While most countries of the world have a dominant health funding system, elements of each of the following funding methods can generally be found in all developed countries.
 - **Direct payments.**
 - **Private Health Insurance**
 - **Social Health Insurance**
 - **Tax Funded Healthcare**

Direct Payments

7. Direct payment by individuals is common, at least for some elements of healthcare, in all developed countries e.g. optician services, prescriptions, dental care, chiropody, GP consultations, diagnostic tests, community nursing, therapies. The most obvious areas for direct payment in the Falkland Islands could be:
 - Payments for more or all costs of most medications,(perhaps up to some annual limit).
 - Payments for most or all dentistry, community nursing, therapy.
 - Payment for GP consultations
 - Contributions for referrals overseas (flights and subsistence)
8. However, we will need to consider the impact on low income families, children and the elderly. Children and the elderly are one of the highest users of healthcare. We would therefore probably give some exemptions. We would also consider means testing to ensure fairness and that people are not disadvantaged by this system. In addition, because we are a small community, the costs of setting up and administering the system would need to be considered. There is no point implementing a system that costs more to administer than it collects.
9. Below are some illustrations of charges that could be involved (based on what is charged elsewhere):
 - Prescriptions £7.10 per item (UK); Prepayment cards – Quarterly £27.85; yearly £102.50
 - Dental £16.20-£198.00 per course of treatment (UK)
 - G.P. Consultation £10.00 approx. (Europe)
10. To give an indication of the amount of revenue that could be raised, if a prescription charge of £5 per item and a consultation fee of £10 is assumed for a visit to a doctor or dentist, this would raise around £150K a year, even if we assume that only ¼ of people will be liable to pay.

Private Health Insurance

11. Apart from the USA, private insurance is typically not the dominant funding model in developed countries. However, it is a feature of health care in many countries as a top up to provide access to a perceived better level of care than that provided universally by the state. There are many different types of insurance but they can be summarised into three main forms:

- Full or complete private insurance – This covers a comprehensive range of services but not 100% of the costs of treatment. Most private health insurance policies involve a range of deductibles and co-payments designed to limit demand and protect the insurer. Insurers will also manipulate premiums for high risk groups which has the effect of discouraging them from taking out insurance
 - Supplementary private insurance – This generally provides additional cover for an individual already covered by a state scheme. It is likely to cover a much narrower range of services or payments as a significant proportion of healthcare needs will still be met by the state. In UK it is mainly aimed at the market for private elective surgery to keep prices down. Some very complex and costly procedures are excluded.
 - Complementary private insurance – This is common in many countries with social insurance funding of health services – covers services that are not seen as essential or at least a high priority for social support (including; spectacles, cosmetic dentistry, therapy services, alternative health provisions.)
12. The main problem with private health insurance is that it tends to create a two-tier service. This is because a fall back service still needs to be provided to cater for those who can't afford (or can't get) insurance. It should also be borne in mind that insurance companies are not philanthropists. Over time, the total value of insurance premiums paid will exceed the cash value of benefits paid for.
13. However, there could be a place for private insurance for specific areas such as medivacs or overseas medical referrals.

Social Insurance

14. This is well developed in most Northern European countries. Many healthcare costs are funded through sickness funds but these are not government run. Sickness funds receive a payment for each person or dependent (typically takes a fixed % from the wages). It is usually compulsory up to some income ceiling to reinforce social solidarity and can be made up of worker and employee contributions. The method is to pay claims directly or reimburse payments as care provided so that patient feels they have purchasing power and can go and buy the care they need.
15. Although the system initially claimed to take politics out of health, governments have had to step in as many countries found their sickness funds inadequate. In our small community it is unlikely that it would be efficient to have a number of different sickness funds. If this route is followed it may be better for the fund to be owned and regulated by the government.

Tax Funded Healthcare

16. This is what is generally known as the Welfare State system (though this usually includes pension provision). The concept originated in Japan but is more commonly known from the Beveridge Report – UK (Social Security and Health Services) published during Second World War. Under this system, the healthcare is funded directly from taxation. This, in the main, is the existing system in the Falkland Islands. The main problem with this system is the ultimate lack of control. Expenditure rises as demands and expectations increase and there is little, if any, link between payments and services in the minds of the public. The system encourages participation without any restriction on demand.

17. On the other hand, this system gives the opportunity for more effective control due to centralisation and national ownership; it is a more equitable method of provision and there is no penalty for those in poorer health or financial circumstances
18. This could be done in the form of a National Insurance Scheme or Medical Services Levy. Such a scheme could be financed by employee contributions or by a mix of employee and employer contributions. Some would argue that any scheme that involves employer contributions would be a tax on employment. However, it is important to remember that a healthy workforce also benefits the business!
19. The following table gives an indication of the amounts of revenue that could be raised each year from a percentage contribution scheme (assuming that there are no earnings limits involved:

	Employee Only Contributions Scheme £	Employee and Employer Contributions Scheme £
1% of earnings	225,000	450,000
2% of earnings	450,000	900,000
5% of earnings	1,125,000	2,250,000

Implications for the Falkland Islands

20. Many of the potential methods of funding health services which have been outlined are more likely to be found in countries with a large population. The larger the population, the greater the scope for competition between methods of funding provision, as the fixed costs of collecting money or providing services can be spread over more consumers, members or taxpayers. In a society as small as the Falklands, it would be unrealistic to expect much competition.
21. We suffer the further difficulty that some types of healthcare are inevitably more expensive for every patient, due to travel and accommodation for patients or providers. This puts us at a disadvantage when trying to encourage private commercial insurers to become involved. Although the higher costs of transport are known or can be estimated by an insurer, they would not necessarily rule out any form of private insurance but they may, however, make premiums substantially higher.
22. It would be possible to have a healthcare system that operates on more than one level. For example, the basic core service could be funded from taxation (perhaps with some chargeable elements). Desirable elements could then be funded from a social insurance scheme of some sort; and 'cosmetic' treatments paid directly by individuals. The amounts that would be raised by a social insurance scheme would be the same as the percentage contribution scheme above.

Some Key Questions:

1. Should we cap Health funding at current levels (meaning that services would fall below UK standards over time?)
2. Can/should we regulate or ration demand by charging for some or all of the services?
3. If we were to initiate charges, should we use Wealth Related Payments (Means Treating)?
4. Is it accepted that private insurance schemes will not be effective?
5. If not, how practical is this in the short term and what would we do in the interim?
6. Would general revenue raising approaches be a better method of funding health?

The public consultation period in relation to this Green Paper will close on 24th April 2009. Please submit your views on these and related issues before that time: either at a public meeting, other meetings called to discuss the Green Paper or by e-mail assembly@sec.gov.fk or in writing to Members of the Legislative Assembly