ROLE OF SUSTAINABLE HEALTH FINANCING IN STRENGTHENING CARIBBEAN HEALTH SYSTEMS

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MAIN THEMES OF PRESENTATION

• Health financing is international issue
• Health financing as instrument of UHC
• Key aspects of Caribbean health financing
• Lessons for health financing policy
• Financing Options for NCDs
• Way Forward--Managed Pluralism Approach (MPA)
OBAMACARE—Mandated Universal Coverage or Individual Choice
# MPA-Health Financing Framework

*(X’s indicate % significance)*

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BUILDING BLOCKS OF HEALTH SYSTEMS

Inputs and Processes -> Outputs -> Outcomes -> Impact

Service Delivery
Financing
Workforce
Information
Medical products, Vaccines & Technologies

Governance-Leadership

Health system performance overview
Promotion of healthy policies
Access to quality preventive public health programs
Access to quality health care services

Personal health services
Community health services

Access
Coverage
Quality
Safety

Effective coverage
Lower prevalence of risk factors and behaviors
Better health policies & regulation

Improved health
Responsiveness
Social and financial protection
Improved efficiency

Modified from:

and

MONITORING THE BUILDING BLOCKS OF HEALTH SYSTEMS
Towards universal coverage

- Reduce cost sharing and fees
- Extend to non-covered
- Include other services
- Financial protection: what do people have to pay out-of-pocket?
- Services: which services are covered?
- Population: who is covered?
### 3 Dimensions of Health Financing

<table>
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<tr>
<th>Core Components</th>
<th>Related Issues</th>
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| i) Generating revenue/funds              | * Who pays? What mechanisms eg taxes, payroll deductions, insurance premiums, direct out of pocket payments, grants?  
* Are funds adequate, predictable, sustainable, affordable? |
| ii) Pooling - Managing funds             | • Is pooling compulsory and equitable? based on risk groups or ability to pay and cross-subsidy/solidarity?  
• Are there single or multiple pooling-fund managers?  
• Does it protect households from catastrophic payments? |
| iii) Spending efficiently                  | • Does spending/purchasing represent value for money in terms of range of needed services?  
• Are health providers paid in a manner that encourages activity, quality and cost control (salary; UCR; DRG/CMG; CPT; contracts/budget; fee per item)? |
REVENUE GENERATING OPTIONS

PUBLIC:--
- Taxes (UK, Sweden, Canada, most Caribbean States)
- Social/National Health Insurance (Germany, France, Japan, Latin America, US ‘Obamacare’)
- Medical Savings Accounts (Singapore)
- Other—loans, grants

PRIVATE:-
- Private Health Insurance
- Out of Pocket Payments-User Fees
- Employer funded plans
- Community funded plans (NGOs)
- Public-private partnerships—capital projects, equipment, contracts
- Philanthropy (foundations, trusts, donations)
HEALTH FINANCING—RISK POOLING

EQUAL INCOMES

Low Risk
Contribution: $$
Net Transfer
Utilisation

High Risk
Contribution: $$

EQUAL RISK

Low Income
Contribution: $
Net Transfer
Utilisation

High Income
Contribution: $$$
Net Transfer
Utilisation
## TYPOLOGY OF HEALTH FINANCING SYSTEMS IN CARIBBEAN

<table>
<thead>
<tr>
<th>Tax/Budget Financing (60+ %)</th>
<th>Social health insurance (SHI) (60+%)</th>
<th>Hybrid (taxes, SHI and private health insurance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anguilla</td>
<td>Aruba</td>
<td>Antigua</td>
</tr>
<tr>
<td>Barbados</td>
<td>Bermuda</td>
<td>Bahamas</td>
</tr>
<tr>
<td>Belize</td>
<td>Cayman Is</td>
<td>BVI</td>
</tr>
<tr>
<td>Dominica</td>
<td>Curacao</td>
<td>Jamaica</td>
</tr>
<tr>
<td>Grenada</td>
<td>St Maarten</td>
<td>T’dad and T’bgo</td>
</tr>
<tr>
<td>Montserrat</td>
<td>Surinam</td>
<td></td>
</tr>
<tr>
<td>St Kitts</td>
<td>Turks and Caicos Is.</td>
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</tr>
<tr>
<td>St Lucia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Vincent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In all countries, fairly high levels of out of pocket payments (mean--33%)
### HEALTH SPENDING vs. OUTCOMES (WHO..2010/11)

<table>
<thead>
<tr>
<th>Country</th>
<th>THE per cap. (US$)</th>
<th>THE%GDP</th>
<th>Life Expectancy (Yrs)</th>
<th>Child Mortality Rate &lt; 5 Yrs (per 1000)</th>
<th>Adult Mortality Rate 15—60 Yrs (per 1000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antigua</td>
<td>651</td>
<td>6.0</td>
<td>74</td>
<td>12</td>
<td>177</td>
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<tr>
<td>Bahamas</td>
<td>1481</td>
<td>7.2</td>
<td>76</td>
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<td>164</td>
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<td>Barbados</td>
<td>974</td>
<td>6.7</td>
<td>76</td>
<td>11</td>
<td>108</td>
</tr>
<tr>
<td>Belize</td>
<td>202</td>
<td>5.2</td>
<td>73</td>
<td>18</td>
<td>166</td>
</tr>
<tr>
<td>Dominica</td>
<td>337</td>
<td>6.0</td>
<td>74</td>
<td>10</td>
<td>147</td>
</tr>
<tr>
<td>Grenada</td>
<td>438</td>
<td>6.7</td>
<td>73</td>
<td>14</td>
<td>197</td>
</tr>
<tr>
<td>Guyana</td>
<td>122</td>
<td>5.4</td>
<td>67</td>
<td>35</td>
<td>257</td>
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<tr>
<td>Jamaica</td>
<td>256</td>
<td>4.8</td>
<td>71</td>
<td>31</td>
<td>177</td>
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<tr>
<td>Haiti</td>
<td>46</td>
<td>6.9</td>
<td>63</td>
<td>70</td>
<td>240</td>
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<td>651</td>
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<td>279</td>
<td>4.5</td>
<td>73</td>
<td>12</td>
<td>160</td>
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<tr>
<td>T&amp;T</td>
<td>908</td>
<td>5.7</td>
<td>70</td>
<td>35</td>
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<tr>
<td>UK</td>
<td>3495</td>
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<td>79</td>
<td>5</td>
<td>74</td>
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<tr>
<td>Cuba</td>
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<td>10.2</td>
<td>79</td>
<td>6</td>
<td>97</td>
</tr>
<tr>
<td>USA</td>
<td>8223</td>
<td>17.6</td>
<td>79</td>
<td>8</td>
<td>104</td>
</tr>
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</table>
OBSERVATIONS FROM DATA REVIEW

a) Total Health Expenditure in Caribbean (WHO/WB..2010-12)

- Average THE of 6% GDP and per capita expenditure of US$600
- Dominated by public—approx. 66%
- High out of pocket/private spending—25%
- Low external support—< 2%

b) Rising costs...declining or stable availability of resources

c) Gaps in availability, quality, timeliness of services...so unmet needs

d) Gaps in ease of access and affordability by certain groups...so avoidable inequities in health (unmet needs)

e) Some persistent inefficiencies in purchasing, inventory management...so excess costs creating gaps above
HEALTH FINANCING DILEMMA

- Aging Population
- BOD—NCDs, Trauma, Infections
- Technology
- Inefficiencies
- Expectations

- Slow Growing Economy
- Demand from Other Sectors
- Less External Support/Grants

Demand for & Cost of Health Services

Availability of Resources

Time Period

$
The shape of things to come

The Economist, Dec. 2003
EQUITY ASPECTS OF FINANCING CHALLENGES

NOT ONLY WILL A POOR MAN HAVE MORE CHANCE OF ENTERING THE KINGDOM OF HEAVEN ... HE'LL ALSO GET THERE SOONER.
<table>
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<th>Key Fiscal Space Factors</th>
<th>General Outlook</th>
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<tr>
<td>i) Real GDP growth</td>
<td>Low to moderate growth over 3 decades; Higher but uneven income distribution.</td>
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<td>ii) Fiscal balance(latest 3 yrs)</td>
<td>10 countries negative; 3 positive</td>
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<tr>
<td>iii) Unemployment/Poverty</td>
<td>4—25% (n=14 countries). Latest year.</td>
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<td>iv) Direct taxes (0--55%)</td>
<td>Trend to stabilisation and reduction. Efficient collections needed.</td>
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<tr>
<td>v) VAT/Sales taxes (0--40%)</td>
<td>Some scope for increase. Efficient collections needed.</td>
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<td>vi) Import duties (0--30%)</td>
<td>Stabilisation OR reduction re: regional &amp; int’l obligations (CSME, WTO, EPA).</td>
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<td>vii) Other taxes eg property; sin taxes (0—10%)</td>
<td>Some scope. Efficient collections needed.</td>
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<td>viii) External Aid (0-10% THE)</td>
<td>Limited scope given graduation.</td>
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<td>ix) Debt (10--140% GDP)</td>
<td>Cautious approach to external debt.</td>
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LESSONS FOR HEALTH FINANCING POLICY

• Use compulsory vs voluntary plans (so no opting out) eg general taxes in UK, or payroll contributions eg Germany
• Optimise existing taxes and/or seek new sources
• Use prepaid vs direct payments (limit OOP to avoid catastrophic expenses)
• Make contributions fair i.e according to ability to pay
• Gov’t should subsidise poor to secure access
• Focus on efficiency—spend wisely not widely—to yield 20-40% more funds (WHO, 2010)
• Target THE should be about 7% GDP with 6% coming from public sources (taxes or contributions)
EFFICIENCY STRATEGIES

A. DEMAND SIDE:
- More illness prevention, health promotion
- Role of primary care team as gatekeepers
- Selective use of copayments/user fees
- Coalitions to confront social determinants of poor health

B. SUPPLY SIDE
- Define/deliver essential needs-based package
- More integrated/coordinated care networks
- Less hospitalisation, more day surgery
- More public-private partnerships in care delivery
- Efficiency in purchasing supplies, equipment, clinical services
- Regional collaboration in sharing services, procurement
LIKELY NCDs FINANCING OPTIONS

• PUBLIC:-
  ➢ Share of more efficient tax collection
  ➢ Dedicated (higher) sin taxes on alcohol, tobacco, processed salted-sugared foods
  ➢ Lottery levies
  ➢ Social security transfers

• PRIVATE:-
  ➢ Diaspora networking
  ➢ Health insurance partnerships
  ➢ Employer funds
  ➢ Selective user fees
  ➢ Philanthropy
CONCLUDING COMMENTS

1. Health is:-
   • multi-dimensional (prevent, advocate, regulate, cure, care, rehabilitate, enhance)
   • Constantly being re-defined with shifting boundaries
   • choice-driven

So need for MANAGED PLURALISM NOT MONOLITHIC MECHANISMS i.e. rationalising mix of public-private financing and provision (See Table)

2. Emphasise compulsory prepaid vs voluntary OOP plans with
   ➢ no opting out
   ➢ fair contributions fair i.e according to ability to pay not risk
   ➢ Gov’t subsidise poor to secure access/avoid catastrophic payments

4. Some rising costs are inevitable, some avoidable..act on these.

5. Focus on efficiency—spend wisely not widely (define membership, define package) esp. in small countries with high unit costs, limited resources.

5. Establish GUARANTEES—availability; quality; timeliness; financial protection
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