ROLE OF SUSTAINABLE HEALTH FINANCING IN STRENGTHENING CARIBBEAN HEALTH SYSTEMS

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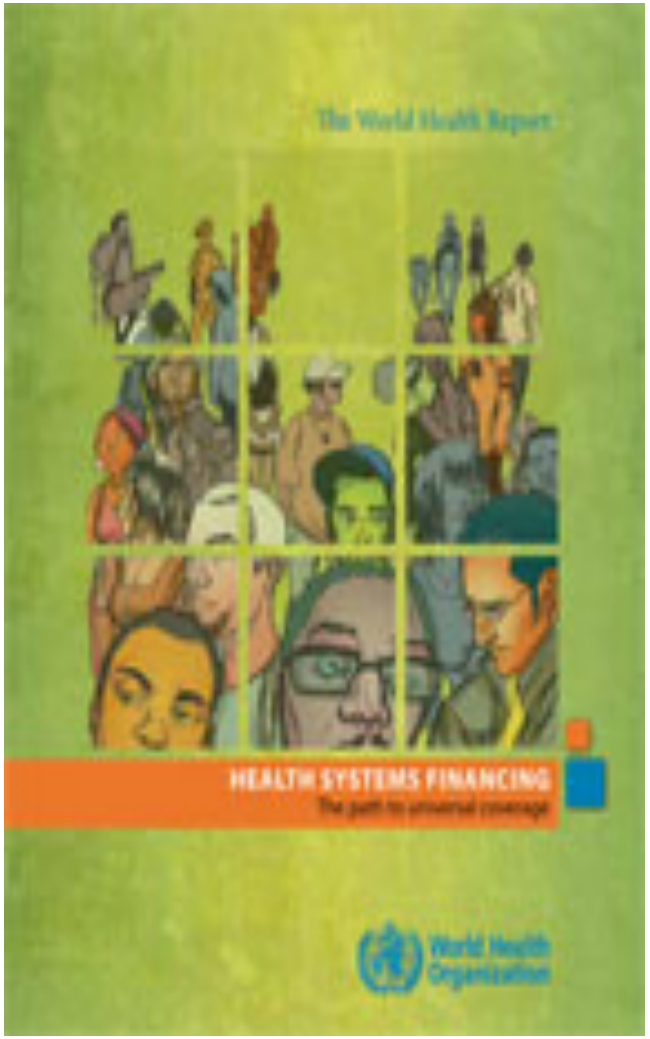
Presented at HCC-CARPHA-PAHO Meeting on Strengthening Health Systems, Supporting NCD Action

Dominica.. October 22, 2014

MAIN THEMES OF PRESENTATION

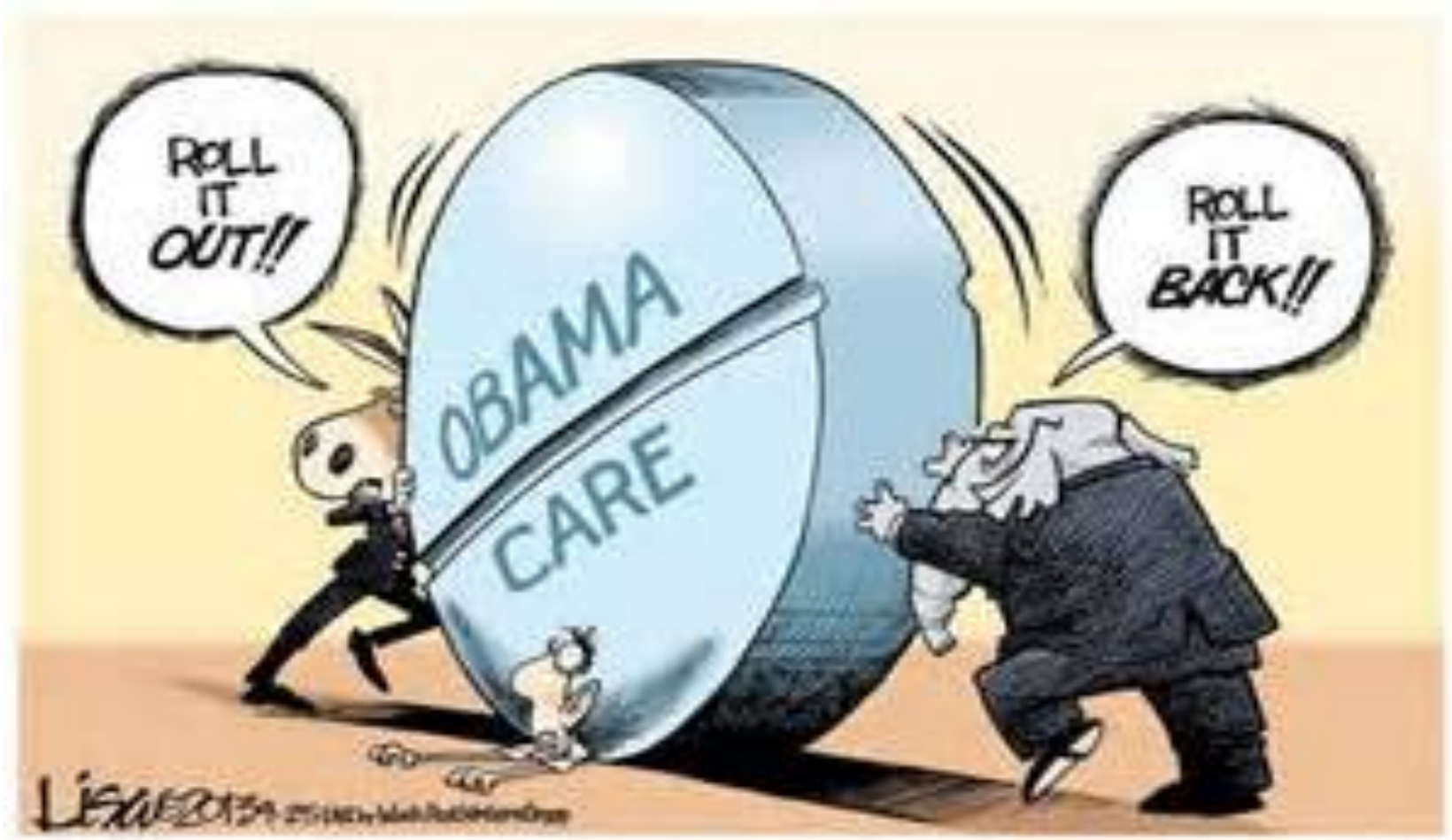
- Health financing is international issue
- Health financing as instrument of UHC
- Key aspects of Caribbean health financing
- Lessons for health financing policy
- Financing Options for NCDs
- Way Forward--Managed Pluralism Approach (MPA)

INTERNATIONAL HEALTH FINANCING CONCERNS



PREPARED BY THE HOUSE COMMITTEES ON WAYS AND MEANS, ENERGY AND COMMERCE, AND EDUCATION AND LABOR
OCTOBER 29, 2009

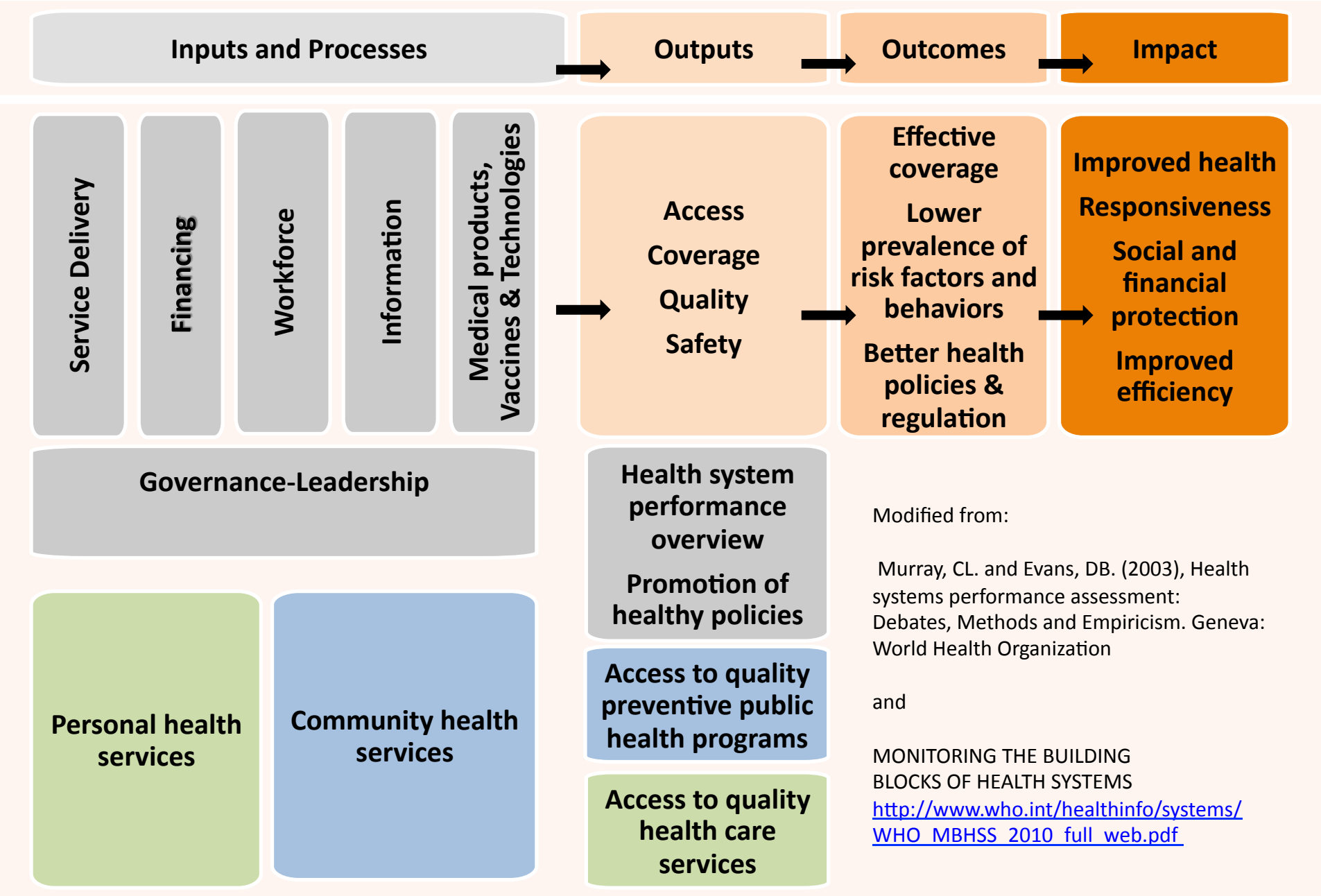
OBAMACARE—Mandated Universal Coverage or Individual Choice



MPA-Health Financing Framework (X's indicate % significance)

Areas	Providers	Taxes	Insurance-SHI,PHI,RHI	OOP	Other (NGO)
Public Health, Regulatory	Public -- MOH	XXX	--	--	--
Ambulatory care (GPs, Specialists)	Private-public	X	XX	X	X
Inpatient Care	Public-private	XX	XX	X	X
Drugs-Diagnostics	Private-public	X	XX	X	--
Long-term care	Private-public	X	X	X	XX
Training-Research	Public- Private	X	X	X	X

BUILDING BLOCKS OF HEALTH SYSTEMS



Modified from:

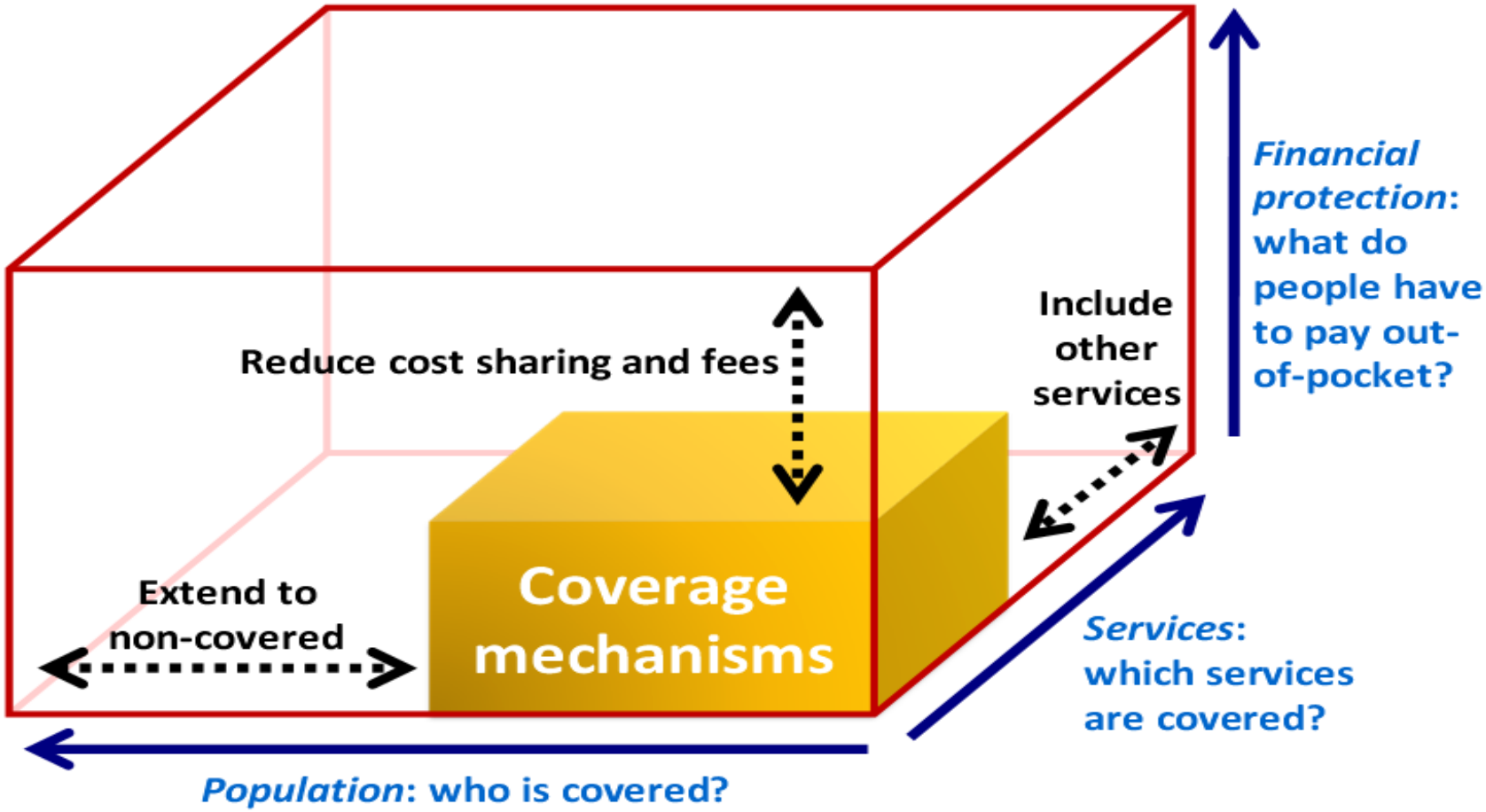
Murray, CL. and Evans, DB. (2003), Health systems performance assessment: Debates, Methods and Empiricism. Geneva: World Health Organization

and

MONITORING THE BUILDING BLOCKS OF HEALTH SYSTEMS
http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf

Sustainability-Universal Coverage Trade-offs

Towards universal coverage



3 DIMENSIONS OF HEALTH FINANCING

Core Components	Related Issues
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

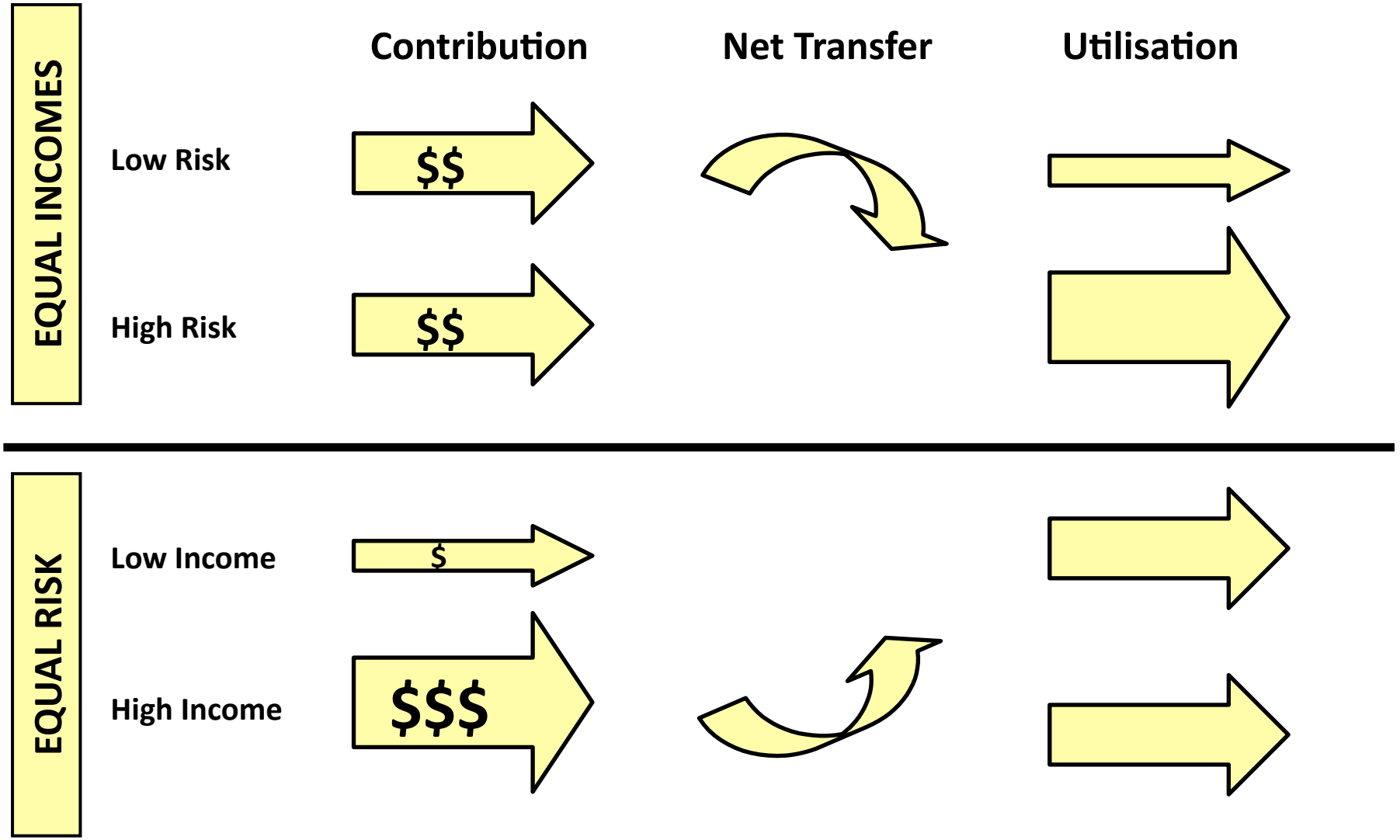
PUBLIC:--

- **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



TYPOLOGY OF HEALTH FINANCING SYSTEMS IN CARIBBEAN

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

IN ALL COUNTRIES, FAIRLY HIGH LEVELS OF OUT OF POCKET PAYMENTS (mean--33%)

HEALTH SPENDING vs. OUTCOMES (WHO..2010/11)

Country	THE per cap. (US$)	THE%GDP	Life Expec-tancy (Yrs)	Child Mortality Rate < 5 Yrs (per 1000)	Adult Mortality Rate 15—60 Yrs (per 1000)
Antigua	651	6.0	74	12	177
Bahamas	1481	7.2	76	12	164
Barbados	974	6.7	76	11	108
Belize	202	5.2	73	18	166
Dominica	337	6.0	74	10	147
Grenada	438	6.7	73	14	197
Guyana	122	5.4	67	35	257
Jamaica	256	4.8	71	31	177
Haiti	46	6.9	63	70	240
St Kitts/Nevis	651	5.8	74	15	138
St Lucia	407	7.0	74	20	139
St Vincent	279	4.5	73	12	160
T&T	908	5.7	70	35	172
UK	3495	9.6	79	5	74
Cuba	583	10.2	79	6	97
USA	8223	17.6	79	8	104

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%

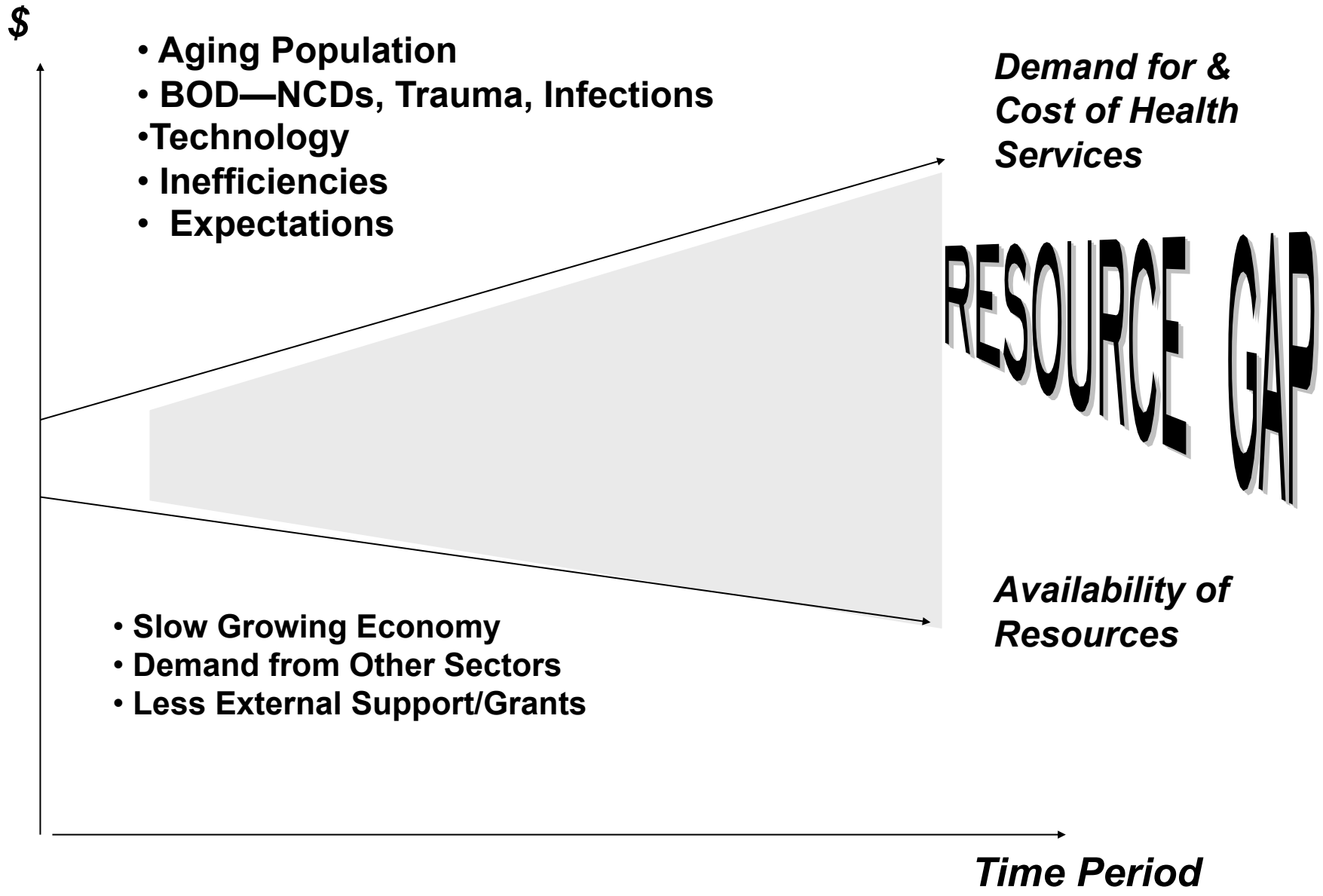
b) Rising costs…declining or stable availability of resources

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)

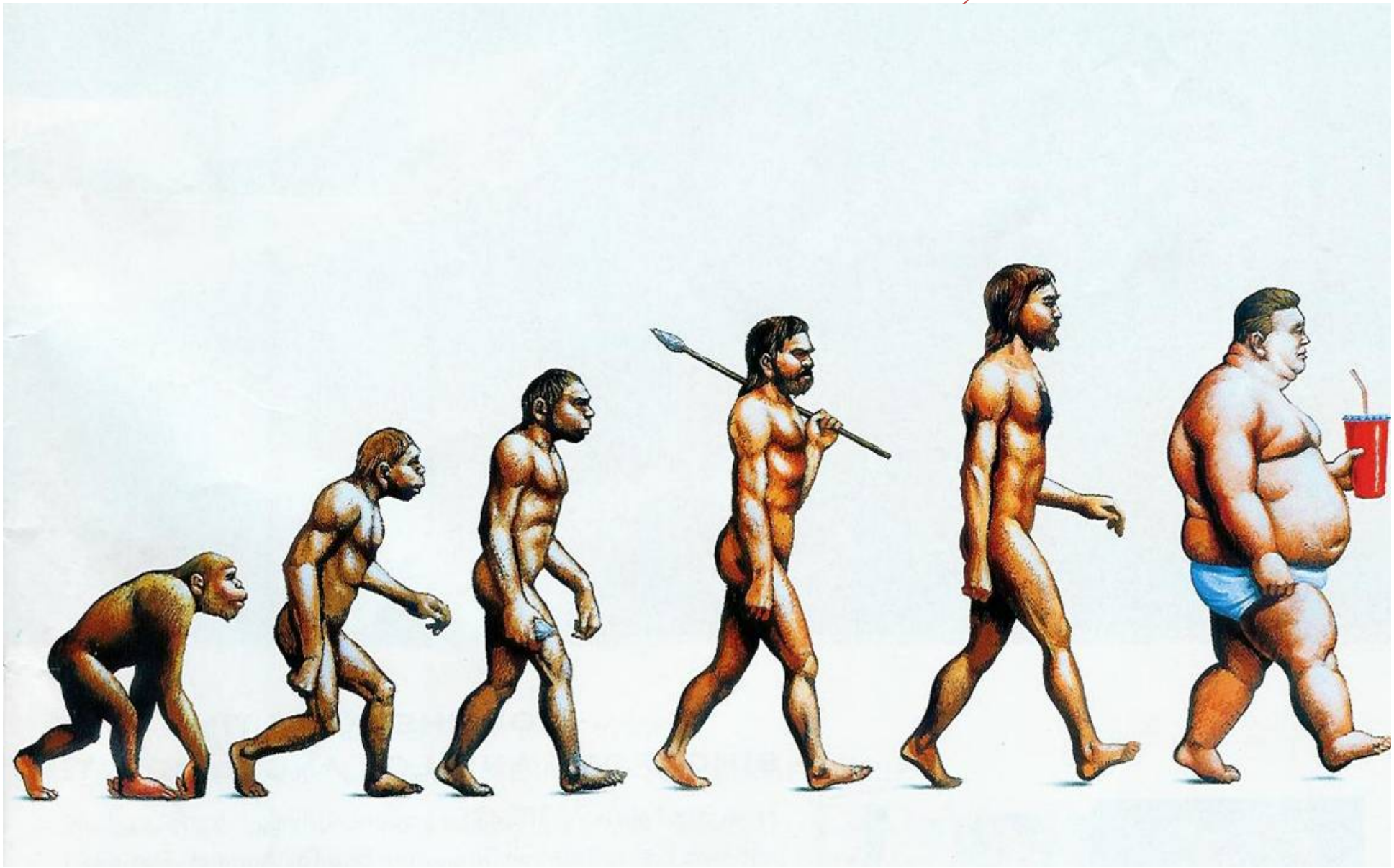
e Some persistent inefficiencies in purchasing, inventory management.. ..so excess costs creating gaps above

HEALTH FINANCING DILEMMA



The shape of things to come

The Economist, Dec. 2003



EQUITY ASPECTS OF FINANCING CHALLENGES

MACRO, FISCAL & SOCIAL SECURITY ENVIRONMENT

Key Fiscal Space Factors	General Outlook
i) Real GDP growth	Low to moderate growth over 3 decades; Higher but uneven income distribution.
ii) Fiscal balance(latest 3 yrs)	10 countries negative; 3 positive
iii) Unemployment/Poverty	4—25% (n=14 countries). Latest year.
iv) Direct taxes (0--55%)	Trend to stabilisation and reduction. Efficient collections needed.
v) VAT/Sales taxes (0--40%)	Some scope for increase. Efficient collections needed.
vi) Import duties (0--30%)	Stabilisation OR reduction re: regional & int'l obligations (CSME,WTO, EPA).
vii) Other taxes eg property; sin taxes (0—10%)	Some scope. Efficient collections needed.
viii) External Aid (0-10% THE)	Limited scope given graduation.
ix) Debt (10--140% GDP)	Cautious approach to external debt.
x) Social security-payroll taxes (5—16.25%)	Limited scope. Focus--secure pension obligations. Business viability issues.

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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Training-Research	Public- Private	X	X	X	X