Health Spending Analysis in Jamaica: Patterns and Projections, 1962-2030

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Presentation at 11th Caribbean Conference on National Health Financing

October 27, 2016

Kralendijk, Bonaire

Objectives of Health Financing

- **Generate adequate revenue—who pays, what mechanisms, efficient collection**
- **Pool risks and funds efficiently—universal coverage, protection against catastrophic costs**
- **Purchase right mix and quantity of services and remunerate providers at reasonable rates**

Pattern of Health Services Provision and Financing,1962-2016

Services	Provision/Agencies	Financing
Public health	Public	Taxes/budget
Ambulatory care (GPs, Specialists)	Private and public	Out of pocket; taxes-budget, insurance, NGOs
Inpatient Care	Public and private	Taxes-budget, out of pocket, insurance, grants
Drugs and Diagnostics	Private and public	Out of pocket, insurance, taxes-budget, NHF
Overseas care	Private, public	Insurance, out of pocket, taxes-budget, grants
Training-Research	Public, Private	Taxes-budget, out of pocket, grants

User Fees Timeline

Type of GOJ Intervention	Time period/ Year
Revised Fees	1968
Removed	c.1975
Reintroduced	1984
Adjusted Upwards	1993
Adjusted Upwards	1999
Adjusted Upwards	2005
Removed for children under 18 years	May 2007 to March 2008
Abolished for all public patients	April 2008 to ??

Other Key Health Financing Sources

i) Out of Pocket (Direct) Payments by Patients

- **Approx. 34% of total health expenditure (2009)**

ii) National Health Fund (2003) and JADEP (1996)

- **Prescription drugs for 15 and 10 chronic diseases resp.**
- **Approx. 500,000 members (19% of population)**
- **Also, funds for health promotion and infrastructure**
- **Approx. J$3bn per year for health (4-5% of total health expenditure in '09)**

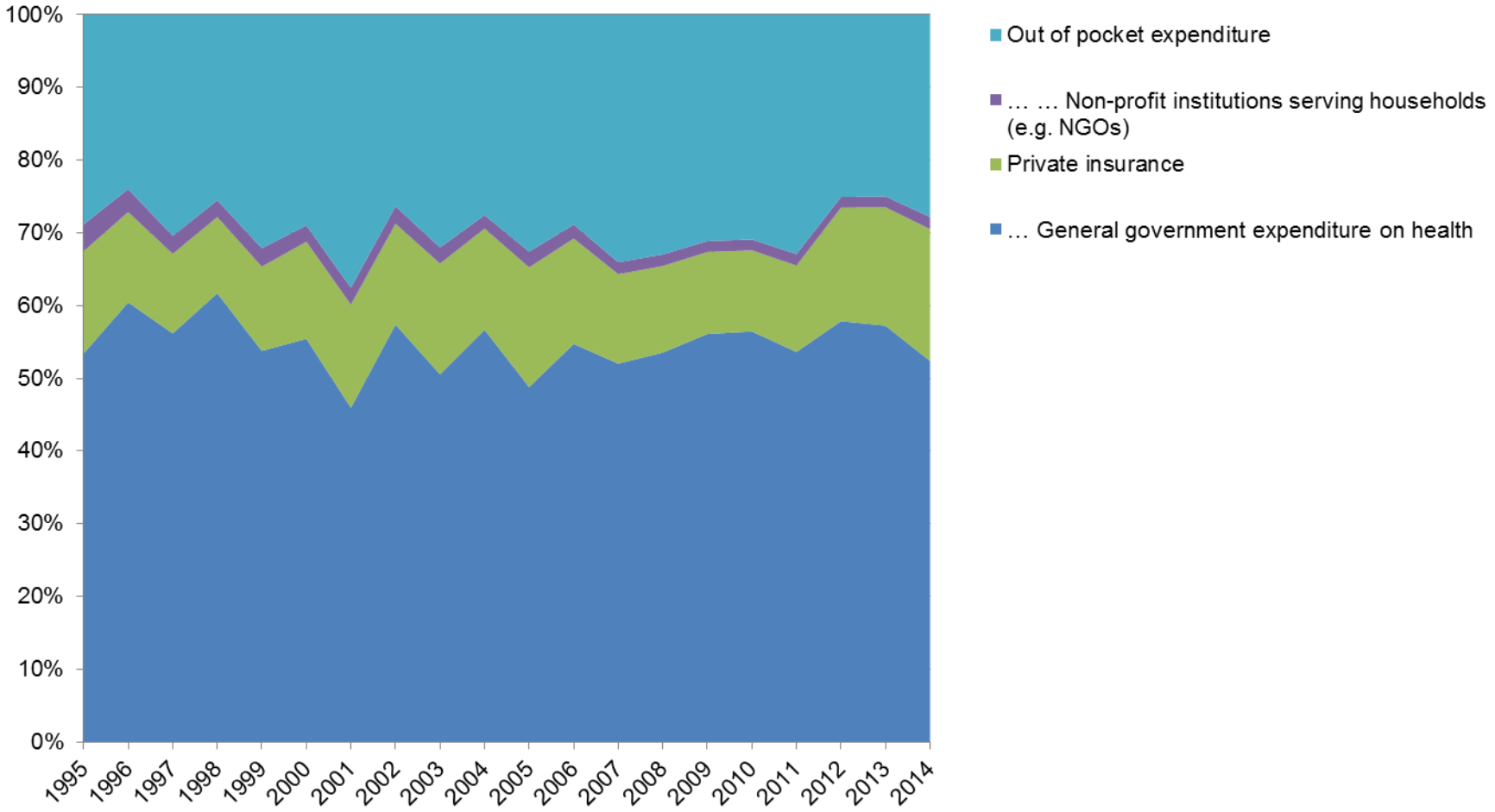
iii) Private Health Insurance

- **Approx. 500,000 persons (19% of pop)**
- **Approx. 14% of total health expenditure**

iv) NGO's, Grants and Donations

*** Accounts for approx. 2%-3% of total health expenditure (2009)**

Composition of Health Expenditure



Pattern of Public Financing, 1962--2012

- Gov't health expenditure (budget) accounted for approx. 50% of total health exp. over period
- Gov't Health Expenditure as % total budget:--
  - 1960's---10%
  - 1970's---8.5%
  - 1980's---6.8%
  - 1990's---5.8%
  - 2000's---5.6%
- Real Gov't health exp. has increased slightly over the period ----approx. 12% over 50 years
- Real per capita gov't health exp. only had a marginal increase over the time period---approx. 3% over 50 yrs

Findings from National Health Accounts Analysis (selected yrs)

Percent	‘95	‘99	‘03	‘08	‘14
THE/GDP	3.6	4.7	4.6	4.6	5.4
GHE/THE	52.6	50.3	50.6	50.0	52.4
PHE/THE	47.4	49.7	49.4	50.0	47.6
GHE/GGE	5.4	5.6	4.5	5.6	10.2
PvtIns/PHE	30.2	25.1	30.8	26.0	38.1
OOP/PHE	61.9	69.5	64.7	71.0	58.4

Components of Public Financing, 1962--2012

- NHF/JADEP
- MOH Budget Allocation (special attention to Overseas assistance and compassionate fund)
- MOE Budget Allocation to UHWI
- Government Insurance Schemes
  - GEASO
  - GPASO
  - NI Gold
  - PSMO (Medical Officers plan)
  - SGE
- Cornwall Regional HMO (COREHELP)
- PATH
- Other MDAs e.g JDF, Correctional Service, etc
- Private Health Insurance/motor vehicle accident insurance/major illness
- MPs' Constituency Fund
- Out of pocket payment
- Official Development Assistance

Quest for Alternative Financing Mechanisms

- **Approx. 24 substantive studies/reports on health financing between 1974-2013**

- **Main Recommendations:-**

- **More Private Health Insurance**
- **More/Less User Fees**
- **Preferred Provider Organization**
- **Medical Savings Account**
- **Earmarked Tax**
- **Prepaid Health Card**
- **Lottery with bulk of profits to health**
- **Social Insurance/ NHI**
- **Public Private Partnerships**
- **Drug Fund**
- **Withdrawing from public body reserves**
- **Telecommunication tax**

NHI—Stop-Go-Stop-Go

1960's…NHI considered as part of NIS

1970's…NHI considered as levy on income for establishment of National Health Service (Green Paper, 1974)

1980's…NHI considered among alternative health financing proposals

1997—Green Paper on NHI

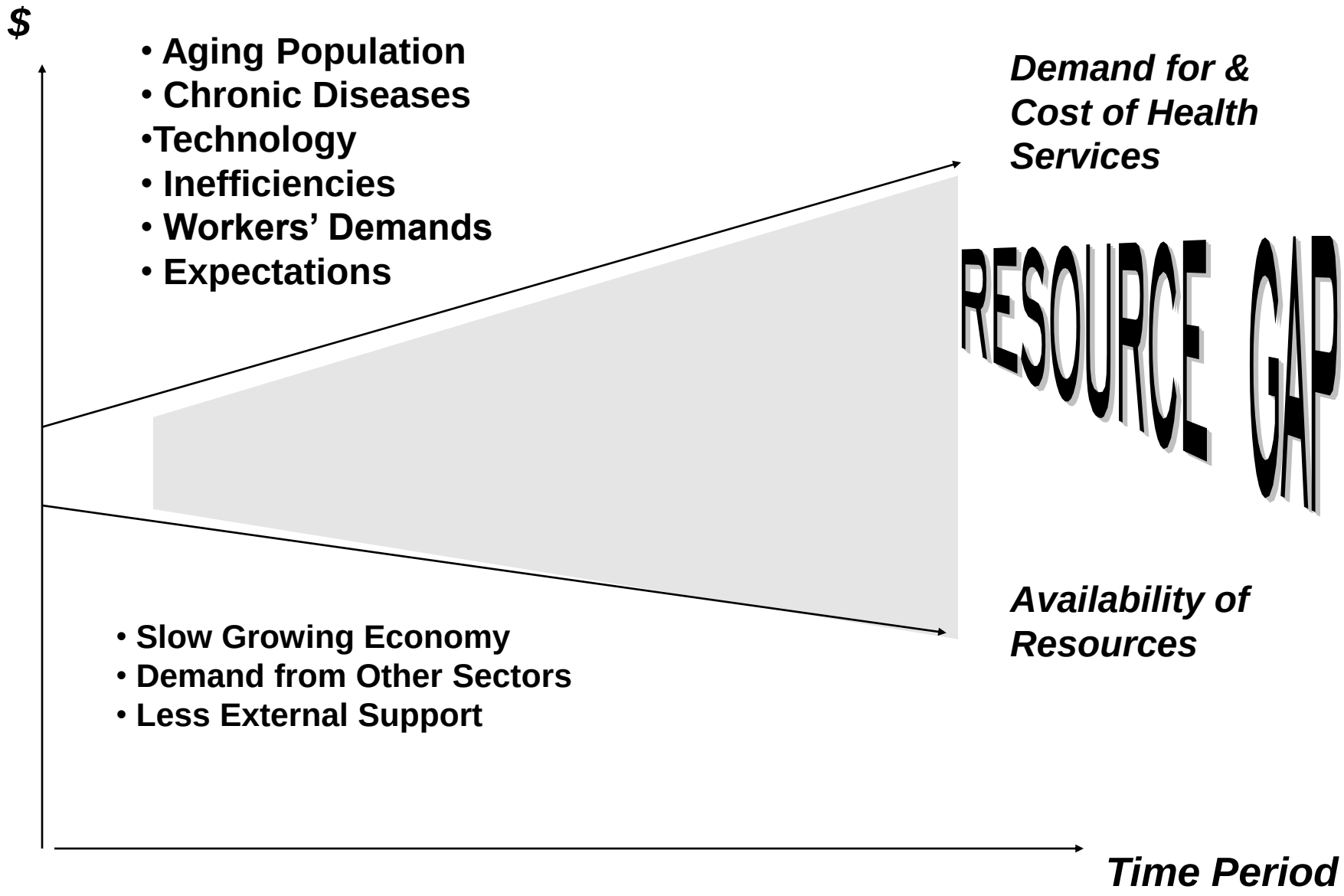
2003—NHF established (first phase of NHI??)

- **Main Design/Implementation Issues—**

- **economic constraints**
- **admin arrangements**
- **contribution from informal (40%) and self-employed.**
- *** package of benefits**
- *** mixed support from stakeholders**

2016 – NHI has been re-instated as priority for the Board

Health Financing Dilemma



Preliminary Inferences

a) Stable Financing Mechanisms--Taxes, OOP, PHI. Only NHF ('03) is new – in additional increases in the tax on tobacco

b) Generally good health outcomes but unevenly distributed (RE: SLC data, 1988-2014)

c) Public financing---gov'ts have struggled to meet funding needs.

d) Private insurance—low coverage (about 15%)—commercially efficient; socially inefficient

e) Out of pocket—very high incidence with greatest burden on the poor and uninsured near poor. (Re: SLC data, 1988-2009)

f) So, universal coverage is still elusive with a 3-tiered system of access (poor go public; insured and non-poor go private; well-off go overseas).

g) For 2012—2062..financing needs will expand significantly, ?% GDP

h) Financing Options—More prepaid plans; diversified public financing sources (direct and indirect taxes); less out of pocket; regional collaboration

i) Definition of essential package for all (services as well as organisational/technological arrangements to deliver package).

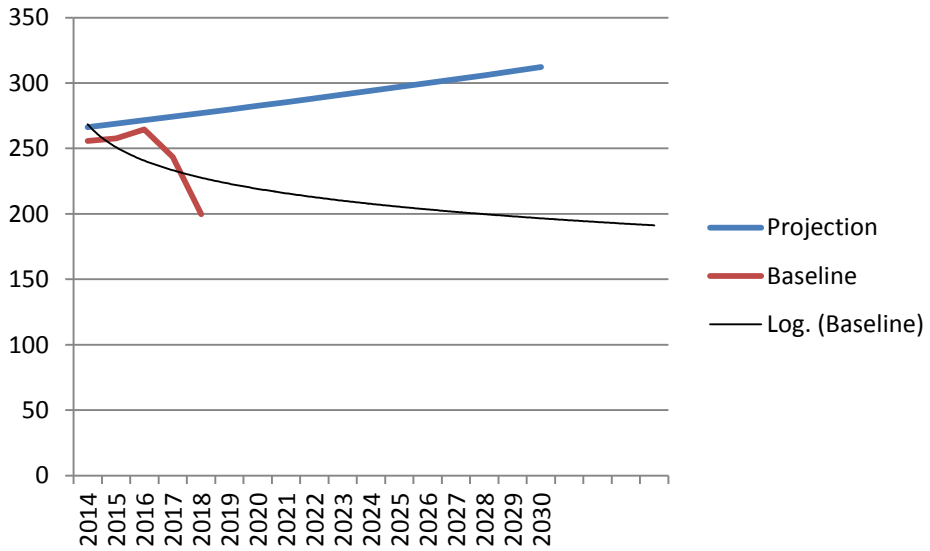
Economic Burden of NCDs and Mental Health by 2030

(USD Billions)

Disease	Burden of Disease
Diabetes	2.34
Cardiovascular Disease	3.55
Respiratory Disease	0.98
Cancer	2.34
Mental Health Condition	2.58
Total NMHs	**17.22**

What the future holds

1% real growth in health spending per capita



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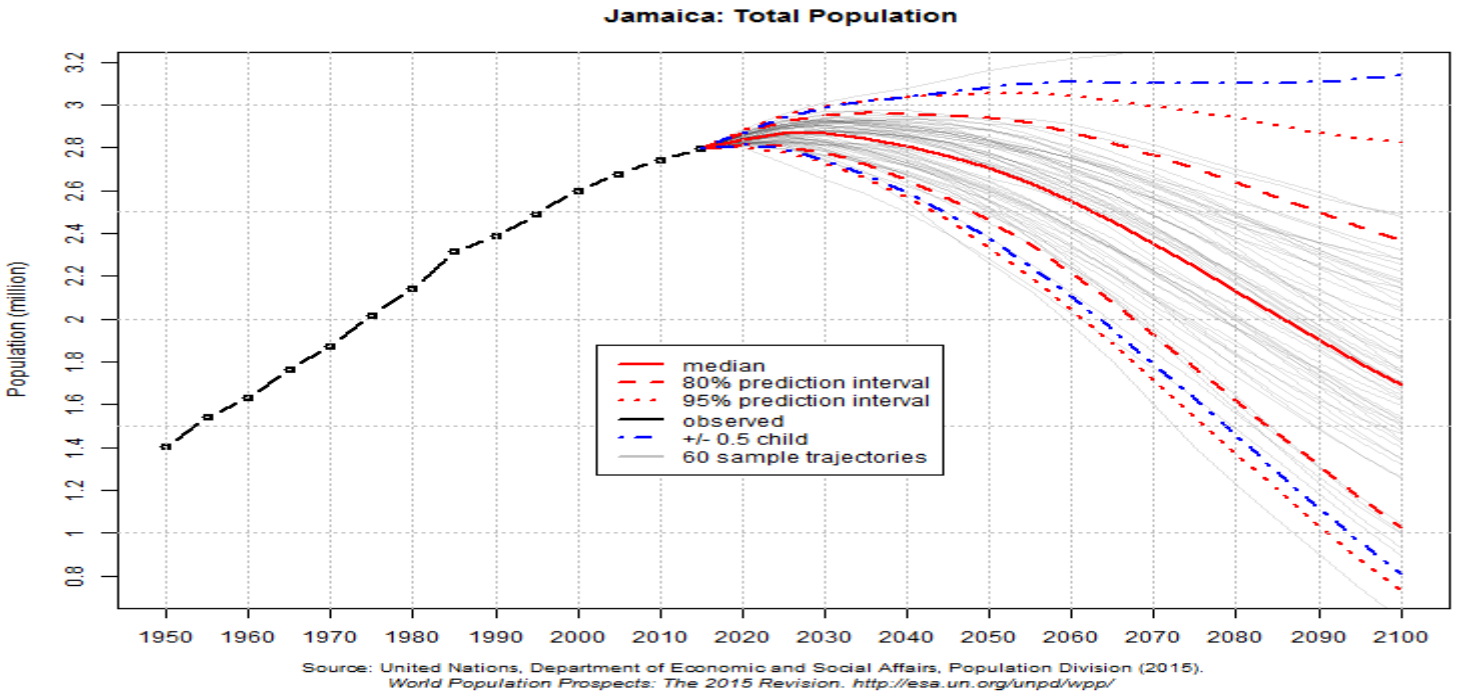
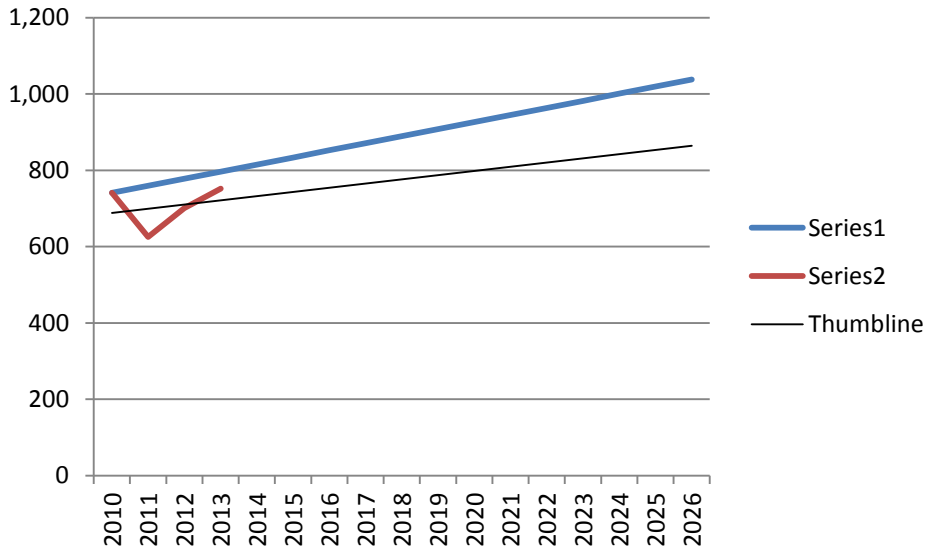


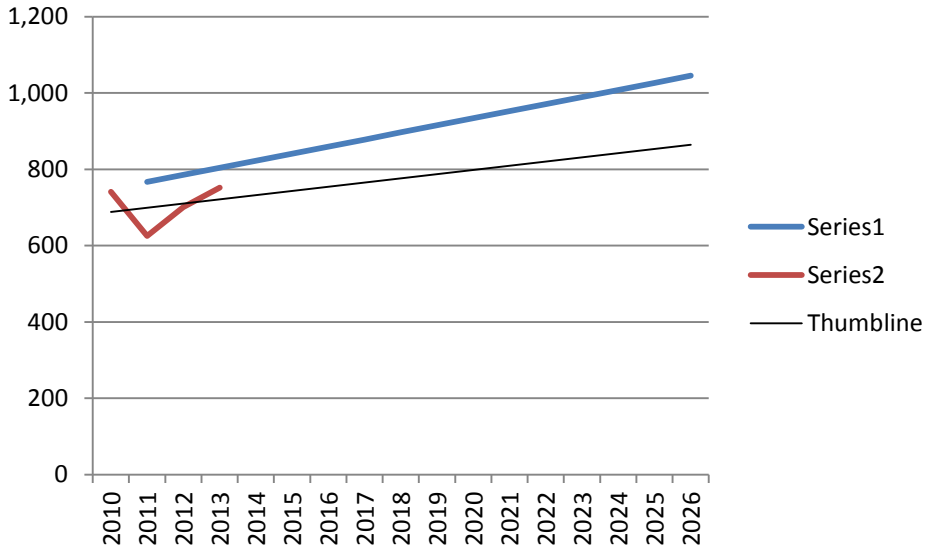
What the future holds

PAHO recommends a minimum of 6% of GDP for government health spending.



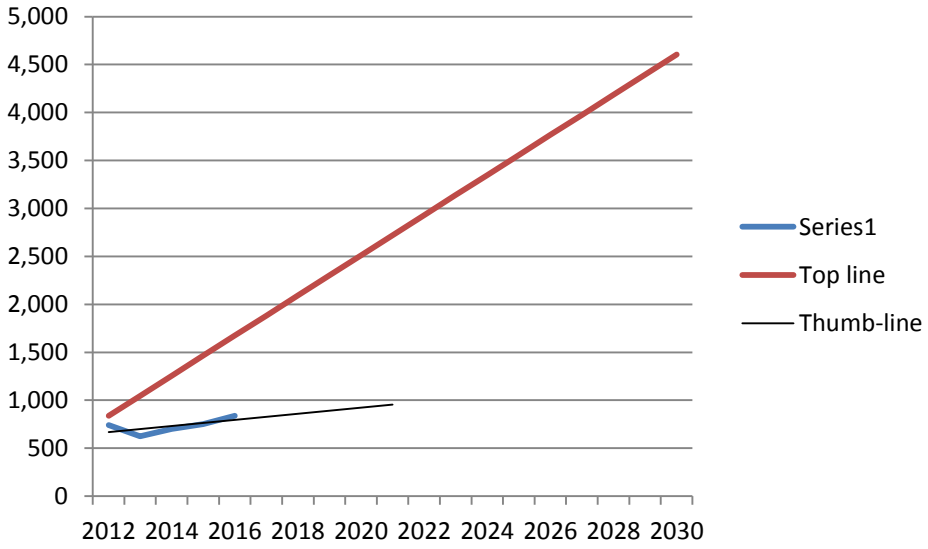
What the future holds

PAHO suggests that 20-40% of health spending is inefficient.



What the future holds

Total spending to increase five-fold from 75,156.6 million JMD in 2012 to 414,241.9 million JMD in 2030.



Future Challenges & Projections

- Demography—aging, urbanisation
- Epidemiology—changing disease patterns, climate change, pandemics,
- Violence & accidents, and health nexus (nearly 9% of GDP loss)
- Technology and Supply-induced Demand
  - Household Income/Health Consumerism—health as 'luxury good'
  - Social—health 'rights'; health consciousness
- Economy and Fiscal Space---macroeconomic projections
- Current Gap analysis—% health spending to GDP (WHO recommendations…at least 6% vs current 3.4% for public financing)