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

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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

<table>
<thead>
<tr>
<th>Services</th>
<th>Provision/Agencies</th>
<th>Financing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health</td>
<td>Public</td>
<td>Taxes/budget</td>
</tr>
<tr>
<td>Ambulatory care (GPs, Specialists)</td>
<td>Private and public</td>
<td>Out of pocket; taxes-budget, insurance, NGOs</td>
</tr>
<tr>
<td>Inpatient Care</td>
<td>Public and private</td>
<td>Taxes-budget, out of pocket, insurance, grants</td>
</tr>
<tr>
<td>Drugs and Diagnostics</td>
<td>Private and public</td>
<td>Out of pocket, insurance, taxes-budget, NHF</td>
</tr>
<tr>
<td>Overseas care</td>
<td>Private, public</td>
<td>Insurance, out of pocket, taxes-budget, grants</td>
</tr>
<tr>
<td>Training-Research</td>
<td>Public, Private</td>
<td>Taxes-budget, out of pocket, grants</td>
</tr>
</tbody>
</table>
# User Fees Timeline

<table>
<thead>
<tr>
<th>Type of GOJ Intervention</th>
<th>Time period/ Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revised Fees</td>
<td>1968</td>
</tr>
<tr>
<td>Removed</td>
<td>c.1975</td>
</tr>
<tr>
<td>Reintroduced</td>
<td>1984</td>
</tr>
<tr>
<td>Adjusted Upwards</td>
<td>1993</td>
</tr>
<tr>
<td>Adjusted Upwards</td>
<td>1999</td>
</tr>
<tr>
<td>Adjusted Upwards</td>
<td>2005</td>
</tr>
<tr>
<td>Removed for children under 18 years</td>
<td>May 2007 to March 2008</td>
</tr>
<tr>
<td>Abolished for all public patients</td>
<td>April 2008 to ??</td>
</tr>
</tbody>
</table>
Other Key Health Financing Sources

i) Out of Pocket (Direct) Payments by Patients
   • Approx. 34% of total health expenditure (2009)

   • 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

- **Out of pocket expenditure**
- … … Non-profit institutions serving households (e.g. NGOs)
- Private insurance
- … General government expenditure on health
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)

<table>
<thead>
<tr>
<th>Percent</th>
<th>‘95</th>
<th>‘99</th>
<th>‘03</th>
<th>‘08</th>
<th>‘14</th>
</tr>
</thead>
<tbody>
<tr>
<td>THE/GDP</td>
<td>3.6</td>
<td>4.7</td>
<td>4.6</td>
<td>4.6</td>
<td>5.4</td>
</tr>
<tr>
<td>GHE/THE</td>
<td>52.6</td>
<td>50.3</td>
<td>50.6</td>
<td>50.0</td>
<td>52.4</td>
</tr>
<tr>
<td>PHE/THE</td>
<td>47.4</td>
<td>49.7</td>
<td>49.4</td>
<td>50.0</td>
<td>47.6</td>
</tr>
<tr>
<td>GHE/GGE</td>
<td>5.4</td>
<td>5.6</td>
<td>4.5</td>
<td>5.6</td>
<td>10.2</td>
</tr>
<tr>
<td>PvtIns/PHE</td>
<td>30.2</td>
<td>25.1</td>
<td>30.8</td>
<td>26.0</td>
<td>38.1</td>
</tr>
<tr>
<td>OOP/PHE</td>
<td>61.9</td>
<td>69.5</td>
<td>64.7</td>
<td>71.0</td>
<td>58.4</td>
</tr>
</tbody>
</table>
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 * package of benefits
• admin arrangements * mixed support from stakeholders
• contribution from informal (40%) and self-employed.

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

- Aging Population
  - Chronic Diseases
  - Technology
  - Inefficiencies
  - Workers’ Demands
  - Expectations

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

Demand for & Cost of Health Services

Availability of Resources

Time Period
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)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Burden of Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>2.34</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>3.55</td>
</tr>
<tr>
<td>Respiratory Disease</td>
<td>0.98</td>
</tr>
<tr>
<td>Cancer</td>
<td>2.34</td>
</tr>
<tr>
<td>Mental Health Condition</td>
<td>2.58</td>
</tr>
<tr>
<td><strong>Total NMHs</strong></td>
<td><strong>17.22</strong></td>
</tr>
</tbody>
</table>
What the future holds

1% real growth in health spending per capita
What the future holds

1% real growth in health spending per capita
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)