

Jamaica is the largest English-speaking island in the Caribbean with a population of approximately 2.8 million (table 1). Though Jamaica's primary health care system was considered a model for the Caribbean region in the 1990's, the nation has lagged far behind in achieving the Millenium Development Goals related to reductions in child mortality and maternal mortality (table 2). Low economic growth and a high debt burden have left limited fiscal space for investments in improved health care.<sup>1</sup>

Jamaica is facing a double burden of disease with non-communicable diseases on the rise while communicable diseases remain a concern.<sup>1</sup>

This disease burden exacerbates the challenge of providing universal health coverage with very limited fiscal space. The abolition of user fees in public facilities (2008) and the growing popularity of the free National Health Fund (2005) - which offsets the cost of pharmaceuticals for a list of 15 priority chronic conditions - have improved access to health care.

However, the chronically low capacity of the medical system as evidenced by low physician and hospital bed density (table 2), among other measures, continues to hamper improvements in health outcomes. It also drives Jamaicans from all income groups to seek care from private facilities when possible so that household health spending is quite regressive.

**Health Finance Snapshot**

Total Health Expenditures (THE) as a percentage of GDP remain relatively low and stagnant at 4 to 5% of GDP.

General government expenditure on health (GGHE) fluctuates but has historically remained low at below 56% of THE.

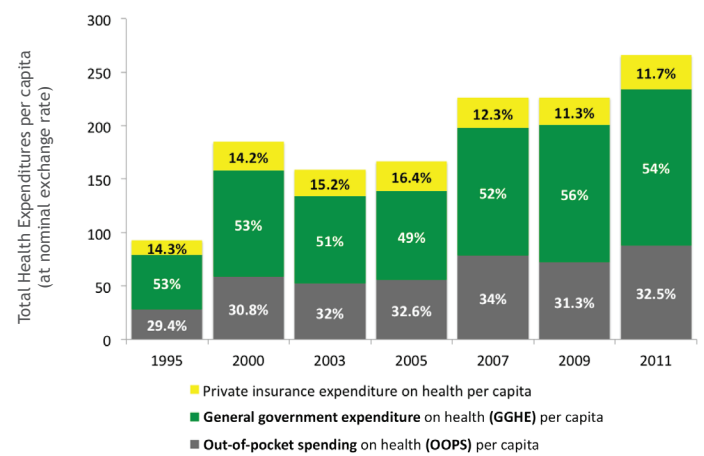
**Table 1. Health Finance Indicators: Jamaica**

	1995	2000	2003	2005	2007	2009	2011
Population (thousands)	2,462	2,582	2,646	2,682	2,709	2,731	2,751
Total health expenditure (THE, in million current US\$)	238	489	430	457	623	628	744
THE as % of GDP	4	5	5	4	5	5	5
THE per capita in USD at official exchange rate	97	189	162	171	230	230	270
General government expenditure on health (GGHE) as % of THE	53	53	51	49	52	56	54
Out of pocket expenditure as % of THE	29.4	30.8	32.0	32.6	34.0	31.3	32.5
Private insurance as % of THE	14.3	14.2	15.2	16.4	12.3	11.3	11.7

Source: WHO, Global Health Expenditure Database; National Health Accounts, Jamaica

- ▶ Out of pocket spending (OOPS) makes up a substantial portion of THE (Table 1, Figure 1).
  - ▶ OOPS does not include private insurance premiums
  - ▶ Most OOPS goes towards pharmaceuticals
  - ▶ Though Jamaica ended user fees in public facilities in 2008, OOPS have remained relatively stable due to increased usage of private facilities, even among lower-income groups

**Figure 1. THE per capita by type of expenditure, Jamaica**



Source: WHO, Global Health Expenditure Database; National Health Accounts, Jamaica

## Health Status and the Demographic Transition

Jamaica is facing a double burden of disease with non-communicable diseases on the rise while communicable diseases remain or have reemerged. While the nation compares well to other upper middle income countries on some measures such as maternal mortality and infant mortality, it lags behind in others such as success rates in treating tuberculosis (table 2).

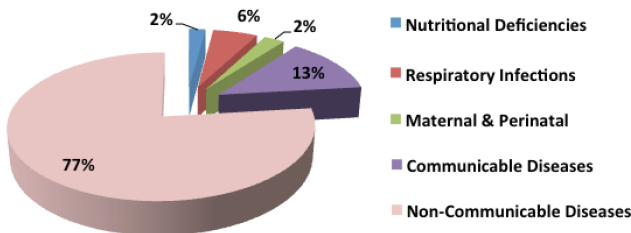
### Demographic Transition

- ▶ Birth and mortality rates are declining (figure 2).
- ▶ The total fertility rate (TFR) has dropped from 3.3 in 1990 to 2.1 in 2012.
- ▶ Life expectancy is increasing.
- ▶ The 'bulge' in the population pyramid is moving upward (figure 3).

### Epidemiological transition

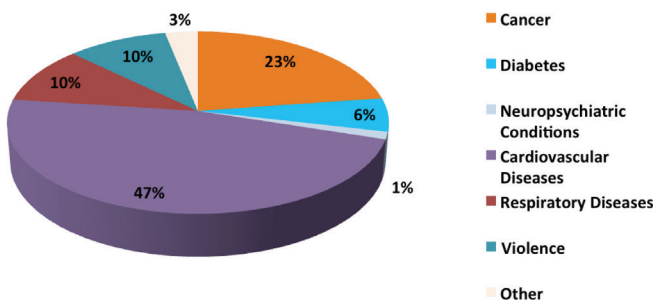
Mortality from non-communicable (chronic) illnesses has surpassed infectious disease mortality (Figures 4 and 5) yet infectious diseases remain a concern accounting for 13% of mortality.

Figure 4. Mortality by Cause, 2008. Jamaica



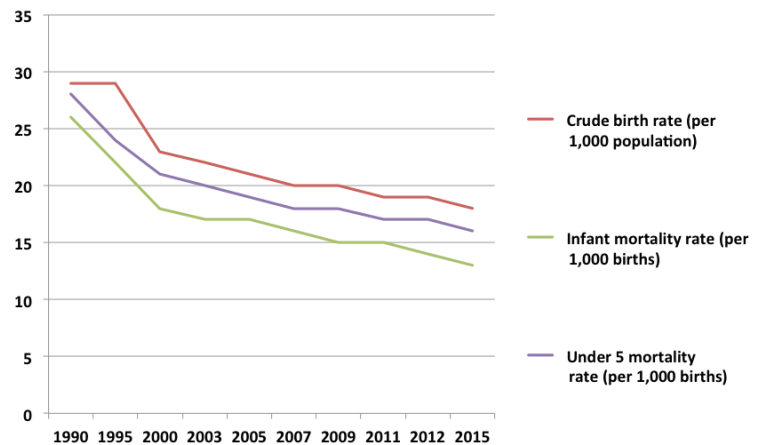
Source: WHO, Global Burden of Disease Death Estimates (2011)

Figure 5. Non-Communicable Disease Mortality



Source: WHO, Global Burden of Disease Death Estimates (2011)

Figure 2. Demographic Indicators: Jamaica



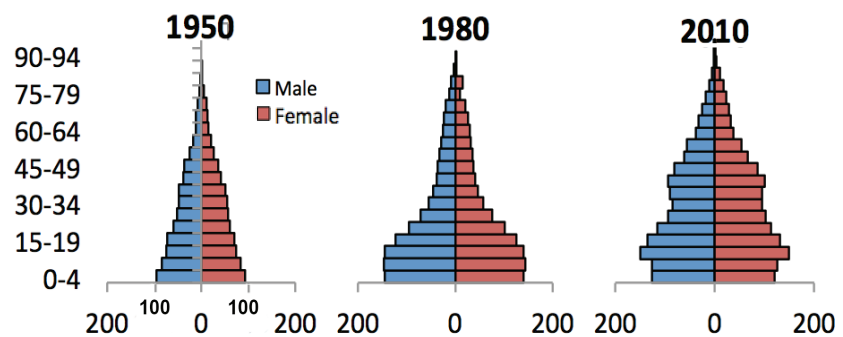
Source: United Nations Statistics Division and the Instituto Brasileiro de Geografia e Estatística, Jamaica.

Table 2. International Comparisons, health indicators

	Jamaica	Upper Middle Income Country Average	% Difference
GNI per capita (year 2000 US\$)	3,345.3	1,899.0	76.2%
Prenatal service coverage	99	93.8	5.6%
Contraceptive coverage	73.7	80.5	-8.5%
Skilled birth coverage	98	98.0	0%
Sanitation	80	73	9.6%
TB Success	70	86	-18.6%
Infant Mortality Rate	20.2	16.5	22.4%
<5 Mortality Rate	23.8	19.6	21.2%
Maternal Mortality Rate	110	53.2	106.6%
Life expectancy	72.8	72.8	0.1%
THE % of GDP	4.8	6.1	-21.3%
GHE as % of THE	40.1	54.3	-26.2%
Physician Density	0.9	1.7	-49.7%
Hospital Bed Density	1.9	3.7	-48.2%

Source: Chao, Shiyun. "Jamaica Effort in Improving Universal Access within Fiscal Constraints", World Bank Universal Health Coverage Studies Series (UNICO) No. 6, 2013

Figure 3. Population Pyramids of Jamaica



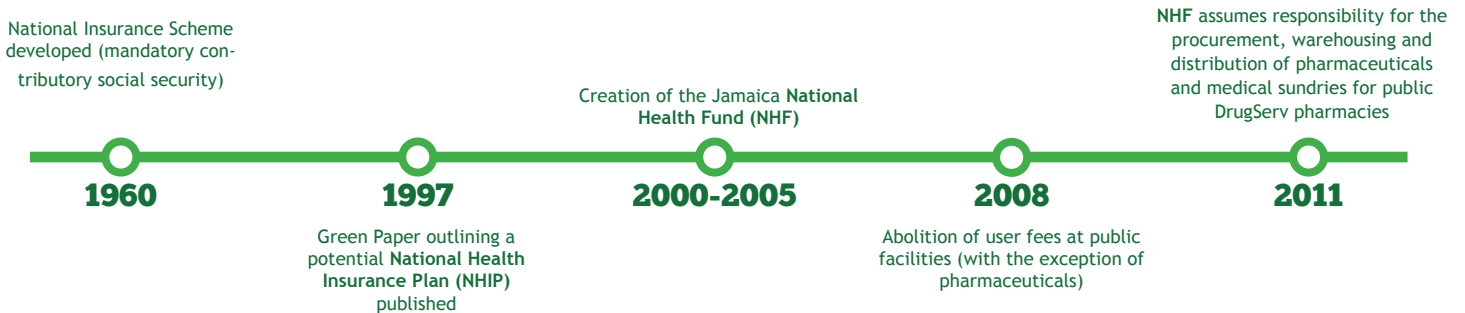
Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: the 2010 Revision

## Health System Financing and Coverage

Jamaica has a two-tiered system whereby the public sector is primarily involved in primary care, public health and hospital care (94% of the country's hospital bed capacity) while the private sector mainly provides outpatient (ambulatory) services (75% of all outpatient care) and pharmaceuticals (82% of all sales).<sup>1</sup> The public sector includes the national **Ministry of Health (MOH)**, the **Regional Health Authorities (RHAs)** and a broad network of primary, secondary and tertiary care facilities as well as the country's medical school. In 1997, the functions of the MOH were decen-

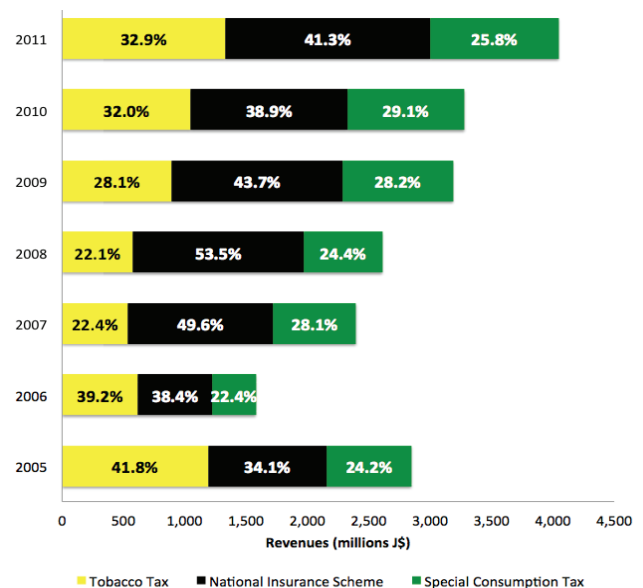
tralized with the **MOH** retaining responsibility for policy, planning, regulatory action and purchasing while the four **RHAs** are now responsible for health service delivery in all 14 Jamaican parishes.<sup>1</sup> User fees were abolished in public health facilities in 2008 (with the exception of pharmaceuticals) so that Jamaica now has universal health care. The inability to meet increased demand, however, has led to poor quality of care, driving Jamaicans from all income groups to increasingly seek private medical care.<sup>1</sup>

Figure 6. Timeline of Jamaica's Unified Health System (SUS)



- ▶ Jamaica's **MOH** is financed mainly through general taxes. Approximately 86% of the **MOH** budget is transferred to **RHAs** for health service provision.
  - ▶ The abolition of user fees in public facilities run by **RHAs** (2008) had several impacts:<sup>1</sup>
    - ▶ The poorest 20% of the population showed a 10% increase in health facility use from 2008-2009.
    - ▶ Conversely, long wait times, insufficient supplies, inadequate human resource levels and poor quality of services in public facilities have driven an increase in usage of private facilities even among the poorest income quintiles.
  - ▶ After the abolition of user fees, the government increased the budget of the **MOH** to compensate for the loss of health facility income.
  - ▶ This increase, however, has not been large enough to fund the increased demand for services particularly in regards to long-term investments needed for the scale-up of human resource levels.
- ▶ The **National Health Fund (NHF)** was created in 2003 and became operational in 2005. The **NHF** is situated within the **National Insurance Scheme (NIS)** which also includes the nation's pension, disability, life and other types of social insurance. The **NHF** is run by a board appointed by the Health Ministry and is funded through three mechanisms (Figure 7):
  - ▶ Tobacco excise taxes;
  - ▶ Special consumption taxes (alcohol, petroleum and motor vehicles);
  - ▶ National Insurance Scheme (mandatory payroll contributions of 0.5% of salary paid by employees and employers as well as by independent workers go to the **NHF**)<sup>2</sup>.
- ▶ The **NHF's** revenues were affected by the relocation of a major tobacco manufacturer (the 'Cigarette Company') in 2006, with the share of revenue from the tobacco tax falling from 41.8% in 2005 to 22.4% in 2007.

Figure 7. NHF Revenues by source



Source: NHF Annual Reports, respective years

## National Health Fund Initiatives

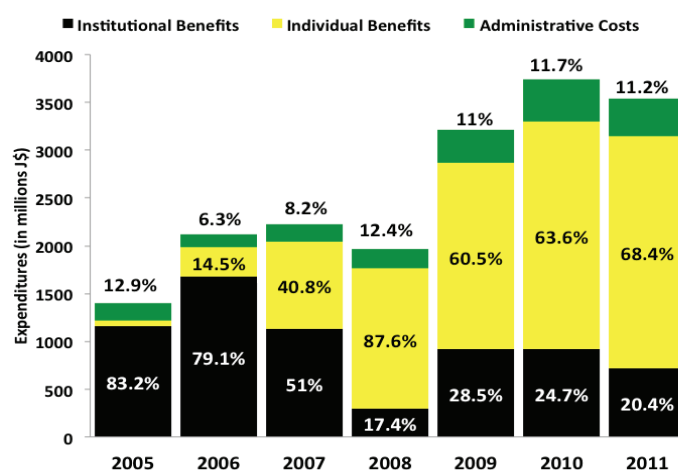
As purchase of pharmaceuticals has historically accounted for a substantial portion of OOPS in Jamaica<sup>1</sup>, the NHF Individual Benefits programs were established to ease the burden of these costs through two types of initiatives:

- ▶ **NHF card** - Provides subsidized medications for a list of 15 chronic illnesses.
  - ▶ Enrollment is free and voluntary but not automatic.
  - ▶ Anyone may enroll (no income or age requirements).
  - ▶ Potential beneficiaries must send or take enrollment forms (filled out by a medical professional) to an NHF office with a turn around time of approximately 2 weeks.<sup>3</sup>
- ▶ **JADEP program** - Provides low-cost medications for a list of 10 illnesses to beneficiaries over 60.
  - ▶ Enrollment is free and voluntary with no income requirements.
  - ▶ Beneficiaries over 60 are allowed and encouraged to enroll in both the NHF Card and JADEP programs to maximize their coverage.
  - ▶ Enrollment may be completed at any public health facility or NHF office.<sup>4</sup>
- ▶ The NHF Individual Benefits programs do not specifically target the poor, rather choosing to prioritize pharmaceuticals for chronic illnesses and for the elderly. This has had a regressive impact on OOPS for pharmaceuticals.<sup>1</sup>
  - ▶ Spending on prescription medications by the richest 20% of the population decreased from approximately US\$50 in 2001 to approximately US\$30 in 2007.
  - ▶ Among the poorest 20%, it increased slightly from approximately US\$12 to US\$14.

The second NHF initiative is the Institutional Benefits Program which provides grants to institutions via two types of funding mechanisms.<sup>5</sup>

- ▶ **The Health Promotion and Protection Fund:**
  - ▶ provides funding for public & private sector projects in educational and primary care activities;
  - ▶ funds activities that are meant to promote healthy lifestyles, protect health and prevent illness.
- ▶ **The Health Support Fund:**
  - ▶ provides funding for public sector infrastructure and development projects that support the national healthcare policy using the Pan American Health Organization's (PAHO) Essential Public Functions.
- ▶ In the early years of the NHF, Institutional Benefits accounted for the vast majority of NHF expenditures, falling precipitously in 2008 (to only 17.4% of NHF expenditures) and have now remained between 20 and 29% of expenditures since 2009 (figure 8).

Figure 8. NHF Expenditures by type



Source: NHF Annual Reports, respective years

## Challenges and Future Agenda

- ▶ Though the NHF has decreased pharmaceutical costs for those undergoing treatment for the priority list of NCDs, private medical appointments for these same patients (even those in lower-income groups) have increased concomitantly, offsetting the savings.
- ▶ Discussions are under way to consider using the NHF as a financier of health services (not only medications) with NHF funding expanding to come from general taxation.
- ▶ A middle-ground is being sought in terms of user fees at public health facilities. A sliding scale system with the poor receiving free care and higher income groups paying progressively higher co-payments based on income is being considered.
- ▶ Simultaneously with plans to expand NHF benefits both in breadth and depth comes the need to increase the MOH budget to increase the capacity of public facilities (infrastructure, human resources, supplies, etc...) to keep pace with increasing demand that is currently being funneled into private facilities with their greater capacity.

## References

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