MINISTRY OF HEALTH & WELLNESS

FINANCING THE COST OF HEALTHCARE IN JAMAICA

Toward Universal Health Coverage
A Discussion Paper

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Executive Summary

What is the financial cost of delivering comprehensive, efficient and equitable healthcare services to the people of Jamaica now and into the future? What does sustainable financing of our health sector entail? What does Universal Health Coverage mean within the context of Jamaica? What, if any are the macroeconomic implications of financing universal health coverage?

This discussion paper seeks to stimulate broad public discussion on sustainable financing of the health sector as we strive towards achieving Universal Health Coverage. There has been previous discussions fixated on user fees, often interchanging revenue collection/raising with health financing. However, the much broader topic, health financing according to the World Health Organization is a policy that focuses on strengthening health system resilience, health security, and universal health coverage. In order to achieve these goals, a country must raise sufficient revenues, maximize risk-sharing across the entire population, spend government funds in ways that improve the health of all citizens of a country, and exercise prudent public financial management.

Jamaica currently lacks adequate funding for the health sector. The COVID-19 pandemic has shown the importance of having a well-funded and resilient healthcare system that can respond to current as well as unexpected and future health catastrophes, as part of a comprehensive approach to public health and national well-being and security.

Countries like Jamaica face the twin challenges of meeting debt service and primary surplus requirements, on the one hand, and making long-term investments in public health, security and human development, on the other.

Without sustainable health financing and increased access to quality health care, more Jamaicans will experience poverty as a result of ill-health and high out-of-pocket payments for health care services. The COVID-19 pandemic has already pushed approximately 120 million people from mostly low- and middle-income countries into extreme poverty. The new global poor are much more likely (82 percent) to reside in middle-income countries (MICs) compared to 60 percent of the existing global extreme poor. Increasing health spending and achieving universal health coverage are important for keeping Jamaicans out of poverty. Total health expenditure for Jamaica remains above 6% of GDP, however, that sustainability is not guaranteed. Sub-optimal health expenditure will result in challenges related to the quality of health care, service delivery, and inadequate investments in human resources, primary care, and universal coverage. Solutions and strategies that can address the gaps in health financing are required.

Urgent attention must be given to:

- An assessment of Jamaica's health financial needs
- Identifying the best health financing model and policy framework for financing the health system
- Pooling of existing resources to mitigate individual-level health risk and increase universal health coverage
- Reducing the likelihood of health-induced poverty by managing the effects of catastrophic expenditure
- Improvements in efficiency and effectiveness of resource use across the health system
- Providing resources to improve primary health care and effective coverage, especially for the most economically and socially vulnerable
- Robust and modern Health Information System, including digitization of medical records for sharing of information and reducing waste and duplication of services

- Bringing services close to the people by overcoming geographic and infrastructural barriers especially with the adoption of technology and engaging with the private sector in order to augment health delivery points
- Full adoption of the “health in all” policies approach to national planning

A national dialogue is important to be had, surrounding the vision for the health sector and the necessary investment needed for health care in Jamaica. The 2018 exercise to conceptualise a universal health care plan for Jamaica proposed that the cost of the benefit package, would be $468.2 billion by 2035. The Investments in primary care, maternal and child care, and health promotion and disease prevention account for 18.4 percent of total spending. Discharges, emergencies, and pharmaceuticals account for 44.3 percent of total spending.

Chapter One: The Policy Context

Vision 2030 Jamaica: National Development Plan

The National Development Plan outlines as National Goal 1: Jamaicans are empowered to achieve their fullest potential and National Outcome 1: A Healthy and stable population. One strategy stipulated to achieve this National Outcome is to introduce a programme for sustainable financing of health care.

Vision for Health 2030: Ten Year Strategic Plan

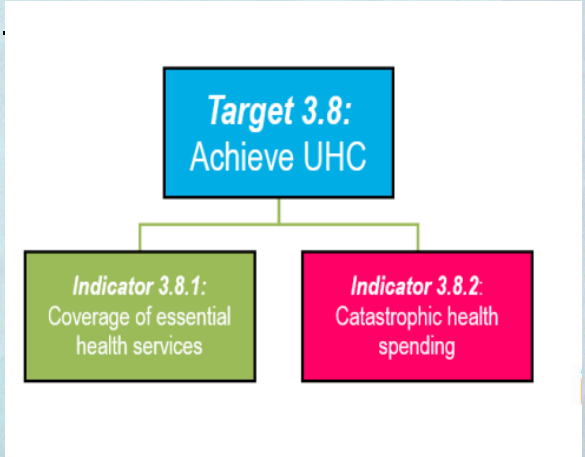
Strategic Goal 3 of the Vision for Health 2030 is Increased and Improved Health Financing for Equity and Efficiency. The Vision for Health 2030 outlines that Health financing as a core function of a health system includes decisions on sources of revenues for the health sector, pooling arrangements and how to allocate those resources to pay for health services that should be guaranteed to the population. Addressing all three, health financing functions comprehensively and in alignment with the other health systems functions is a necessary condition for moving towards Universal Health. The Strategic Outcomes of this Strategic Goal are:

- Strong advocacy for the increase in the amount of funds provided to the public health sector to ensure government expenditure on health is 6% of GDP
- Improved efficiency of how funds provided to the public health sector is allocated and utilized for the delivery of health care services
- Increased allocation of funds to the first level of care (primary care) to at least 30% of the budget for the public health sector
- Consolidate the number of GOJ sponsored public insurance schemes to optimize efficiency
- Introduction of a Package of services/Benefit Package guaranteed to all resident Jamaicans without user fees at the point of service in the public health sector

International and Regional Mandates

Sustainable Development Goals

Figure 1: UHC service components



Target 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

The average coverage of essential health services based on tracer interventions, including reproductive, maternal, newborn, and child health, infectious diseases, noncommunicable diseases, and service capacity and access, is defined as SDG 3.8.1 coverage of essential health services among the general and most disadvantaged populations. Indicator 3.8.2 is defined as "the proportion of the population with high household health expenditure as a share of total household expenditure or income.[1]"

PAHO Strategy for Universal Access to Health and Universal Health Coverage

This strategy establishes four simultaneous, interdependent strategic lines to guide, as appropriate, the strengthening of health systems with a view to achieving universal access to health and universal health coverage. The four Strategic Lines are as follows:

a) expanding equitable access to comprehensive, quality, people- and community-centered health services;

[1] https://www.who.int/data/gho/data/themes/topics/financial-protection, accessed:27 April 2023

b) strengthening stewardship and governance;
c) increasing and improving financing with equity and efficiency, and advancing toward the elimination of direct payments that constitute a barrier to access at the point of service; and
d) strengthening multisectoral coordination to address the social determinants of health that ensure the sustainability of universal coverage.

Alma-Ata Declaration of 1978

The Alma-Ata Declaration emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health care as the key to the attainment of the goal of Health for All. It expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world. Its significant influence on global health care has prompted increased primary healthcare spending as well as the creation of creative access-improving strategies.

The Declaration of Astana of 2018

The Astana Conference based on the groundwork of Alma-Ata by uniting partners to embrace another announcement sensitive to the difficulties of the 21st hundred years, and to reexamine the standards of Alma-Ata with a more profound comprehension of their viable ramifications in this day and age. Member States, including Jamaica, thus reaffirmed their commitment to the fundamental right of every human being to the enjoyment of the highest attainable standard of health without distinction of any kind and to the values and principles of justice and solidarity in the Declaration of Astana, underscoring the significance of health for socioeconomic development, peace, and security.

In order to adequately respond to ongoing and new health and health system challenges, as well as to take advantage of new resources and opportunities for success in the 21st century, it is recognized that aspects of primary health care need to be updated. The Declaration presents 3 interconnected components: empowered populations and communities that can prioritize and co-design responses to their health needs; high-quality primary care, integrated with public health; and multi-sectoral policy and action. Participants confirmed their commitment to primary health care as a means of achieving universal health coverage and the 2030 Agenda for Sustainable Development by signing the declaration.

Chapter Two: Jamaica's Health Profile – Brief Overview

Jamaica's public health sector is facing the increasing challenge of addressing non-communicable diseases (NCDs), the threat of emerging and re-emerging communicable diseases, and the prevalence of intentional and unintentional injuries. In 2020, NCDs were the cause of death for almost 8 out 10 (77%) deaths that year.[2] The COVID-19 pandemic has demonstrated that the possibility of communicable diseases resurging remains a significant public health concern. These threats on the health care system can have a significant impact on health financing, making it more difficult to provide high-quality, accessible healthcare services to the population.

Mortality

The top 5 leading causes of death in Jamaica (2020) were Diabetes Mellitus, Cerebrovascular Diseases, Hypertensive Diseases, Ischaemic Heart Diseases and Assault as seen in Table 1 below.

Table 1. Top 10 causes of death in Jamaica aged 5 years and older

Conditions	No. of Deaths	%
Diabetes mellitus	2,829	**13%**
Cerebrovascular diseases (Stroke)	2,474	**11%**
Hypertensive diseases	1,697	**8%**
Ischaemic heart diseases	1,689	**8%**
Assault	934	**4%**
Malignant neoplasms of digestive organs	919	**4%**
Malignant neoplasm of prostate	736	**3%**
Other forms of heart disease	530	**2%**
Chronic respiratory diseases	483	**2%**
Malignant neoplasm of breast	472	**2%**
Total no. of deaths (Top 10)	**12,763**	**58%**
Other Causes	**9,259**	**42%**
Total no. of deaths in Jamaica, 5 years and older	**21,055**	**96%**
Total no. of deaths in Jamaica, aged 5 years and younger	**967**	**4%**
TOTAL No of Deaths	**22,022**	

Source: MOHW (2023). Vitals: A Quarterly Report of the Ministry of Health. Non-Communicable Diseases edition.

[2] MOHW (2023). Vitals: A Quarterly Report of the Ministry of Health. Non-Communicable Diseases edition.

With high mortality due to non-communicable diseases, and an ageing population, Jamaica is at risk of experiencing high cost to provide healthcare services and a significant increase in potential years of life lost. In 2020, NCD deaths resulted in the loss of 144,853 years of potential life, indicating a 30% rise in potential years of life lost compared to the previous year. This translates to an additional 33,775 years lost per year over the course of a decade. The rate of increase in potential years of life lost among individuals who died from NCDs exceeded that of all causes, with NCDs showing a 30% increase compared to 19% for all causes.

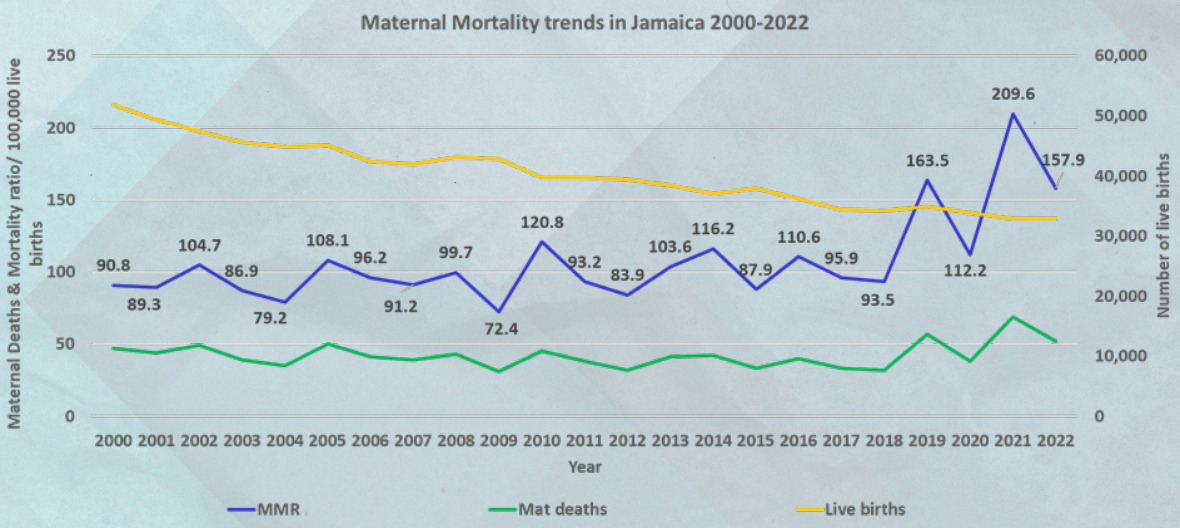
Table 2: Potential Years of Life Lost based on condition in 2020

Conditions	No. of early deaths	No. of potential years lost	Potential years of life lost per 100,000 population
Top 10 major illnesses	**6,479**	**109,983**	**4,199**
Assault	928	33,098	1,264
Diabetes mellitus	1,359	18,087	691
Cerebrovascular diseases	978	12,070	461
Ischaemic heart diseases	805	10,583	404
Hypertensive diseases	725	10,313	394
Malignant neoplasms of digestive organs	628	8840	338
Malignant neoplasm of breast	348	6528	249
Other forms of heart disease	258	4875	186
Chronic respiratory diseases	225	3178	121
Malignant neoplasm of prostate	308	2340	178

The infant mortality rate decreased in 2019 to 15.2 deaths per 1000 live births and increased in 2020 to 16.7 deaths per 1000 live births with the top five leading causes of infant death being: respiratory distress of newborn; remainder of perinatal conditions;

other respiratory conditions of newborn; bacterial sepsis of newborn; and other congenital malformations. The annual number of live births in Jamaica has steadily decreased over the last two decades from over 50,000 to approximately 35,000 live births each year. The number of maternal deaths and consequently the Maternal Mortality Ratio (MMR) has fluctuated as evidenced in Figure 2 below.

***Figure 2**. Maternal Mortality Trends in Jamaica 2000-2022*



Intentional and Unintentional Injuries

In 2014, violence-related injuries and road traffic crashes were the 3rd and 11th leading causes of premature death in Jamaica respectively. In 2021, the number of road fatalities was 432, the highest number of fatalities recorded in Jamaica since 2002. As shown in Figure 2 below, 88 percent of the road fatalities recorded in 2021 were males, while 12 percent were females.

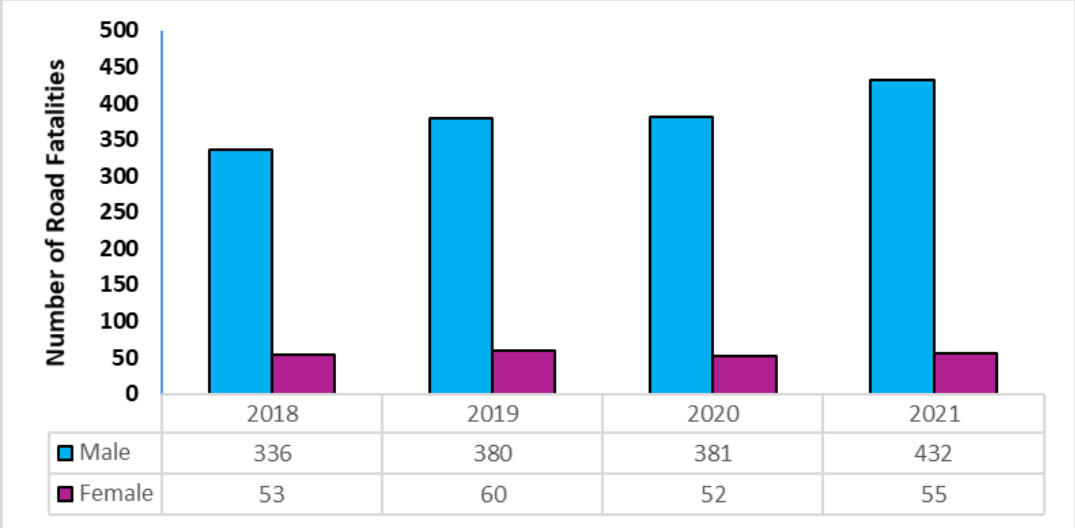


Figure 3. *Road Fatalities Disaggregated by Sex*

Morbidity

Non-Communicable Diseases (NCDs) and morbidity as a result of NCDs are prevalent in low and middle income countries[3]. The 2016/17 Jamaica Health and Lifestyle Survey highlighted Obesity, Diabetes Mellitus, Hypertension, High Cholesterol, Heart Attack, Cancer and Stroke as the most prevalent NCDs (see Table 3).

[3] Population Reference Bureau (2013). Non-communicable Diseases in Latin America and the Caribbean: Youth are Key to Prevention. Retrieved from https://toolkits.knowledgesuccess.org/sites/default/files/noncommunicable-diseases-latin-america-youth-datasheet.pdf

Table 3. Prevalence of Non-Communicable Diseases and Risk Factors: 2016-2017

	Prevalence (%)		
Condition	**Total**	**Male**	**Female**
Hypertension	33.8	31.7	35.8
Diabetes	11.9	9.0	14.6
Pre-diabetes (Fasting glucose 5.6-6.9 mmol/l)	12.0	10.7	13.1
Low physical activity	81.6	80.5	82.6
Pre-obese	25.2	24.0	26.4
Obese	28.6	14.9	41.2
High cholesterol (total cholesterol >= 5.2 mmol/l)	17.8	15.8	19.7
High sodium intake (> 2 g/day)	**60.7**	**72.8**	**66.6**
Low potassium intake (< 3.5 g/day)	**88.8**	**85.1**	**92.3**
Depression	**14.3**	**9.9**	**18.5**

Source: Epidemiological Profile, National Epidemiology Unit (2023). Adapted from Jamaica Health and Lifestyle Survey 2016-2017. Ministry of Health and Wellness and Caribbean Institute of Health Research, UWI (Unpublished)

These diseases share four common behavioral risk factors: tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. The increased burden of NCDs continues to place a strain on healthcare in both primary and secondary care services as well as pharmacy services. The government has taken a multi-sectoral approach to combat the harmful effects of NCDs; rooted in the Ministry's Ten Year Strategic Plan: Vision for Health 2030 under Strategic Goal 5: Social Participation and Health Promotion to Address the Social Determinants of Health. The Ministry is committed to reducing premature mortality and morbidity associated with NCDs.

Vector Bourne Diseases

Dengue, Chikungunya and Zika

Dengue is endemic to Jamaica and remains one of the fastest spreading mosquito-borne diseases. There was a global dengue outbreak in 2019 with Jamaica recording unprecedented dengue cases, which precipitated a one billion Jamaican dollars investment in the Enhanced Vector Control Programme (EVCP). For 2019, there were 9,909 suspected, presumed and confirmed cases of dengue for the period, 179 of which were confirmed cases (MOHW, 2020). There were 51 dengue related deaths recorded

for the period January 1, 2018 to October 29, 2019. The EVCP takes a multisectoral approach involving the Ministry of Local Government and Rural Development (MLGRD) and its agencies, the National Solid Waste Management Authority and other bodies to reduce the aedes aegypti mosquito population.

Communicable Diseases – The Threat of Emerging and Re-emerging Diseases

COVID-19

As the World Health Organization (WHO) states, COVID-19 has taught us that health is not a luxury item for those who can afford it, but the foundation of social, economic and political stability. It has also taught us that no one is safe until everyone is safe. As at April 25, 2023 the total number of COVID-19 cases is 154,787. In response to rising positive case counts, the Government of Jamaica through the Ministry of Health and Wellness organized numerous public education and vaccination campaigns to promote inoculation among the population and contain the spread of the virus. As at April 26, 2023, the Ministry has successfully administered 1,524,738 doses to the population through its vaccination campaign. Of this figure, 757,418 people have received at least two doses, which is approximately 28% of the population.

Monkeypox

The monkeypox (mpox) virus was first identified in Jamaica in July 2022. The WHO declared the global ourbreak of the monkeypox virus as a Public Health Emergency of International Concern on July 23, 2022. As at March 26, 2023 there were 21 confirmed cases of monkeypox in Jamaica and one coincidental death. In response to the current outbreak, the Ministry developed and implemented protocols for surveillance and infection, prevention and control (IPC), case investigation forms and clinical management guidelines. The National Public Health Laboratory developed in country capacity for diagnostic testing for Monkeypox in June 2022. The current capacity is with Polymerase Chain Reaction, PCR analysis for approximately 4,000 samples. Jamaica, on October 17, 2022, received its first batch of 1,400 single dose vials of the JYNNEOS vaccines.

HIV

In 2017, the estimated HIV prevalence in the general population was 1.8% and in 2019, the estimated prevalence was 1.5%. The marked decrease shows a tangible change in trajectory of the HIV epidemic in the country. The stark realities of a concentrated HIV epidemic is evident in Jamaica as the alarming HIV prevalence among key populations described in Table 4 below.

Table 4: Estimated HIV Prevalence in Jamaica, 2019

Population Category	Prevalence (%)
General Population	1.5%
TGW (2018)	51.0
MSM (2018)	29.6
Homeless (2014)	13.9
Prison Inmates (2018)	6.9
FSW (2017)	2.0

Source: Global AIDS Monitoring Report. Jamaica 2020. Ministry of Health & Wellness

Nationally, as of the end of January 2023, there were 19,252 People Living with HIV (PLHIV) ever linked to care. Overall, 15,737 PLHIV have been retained in care, representing 82% of all PLHIV ever linked to care. Furthermore, 14,700 (76%) PLHIV linked have been retained on ARV medication with 12,457 (65%) having a valid viral load test (VL uptake) and 11,347 (59%) of the PLHIV population ever linked to care being virally suppressed.

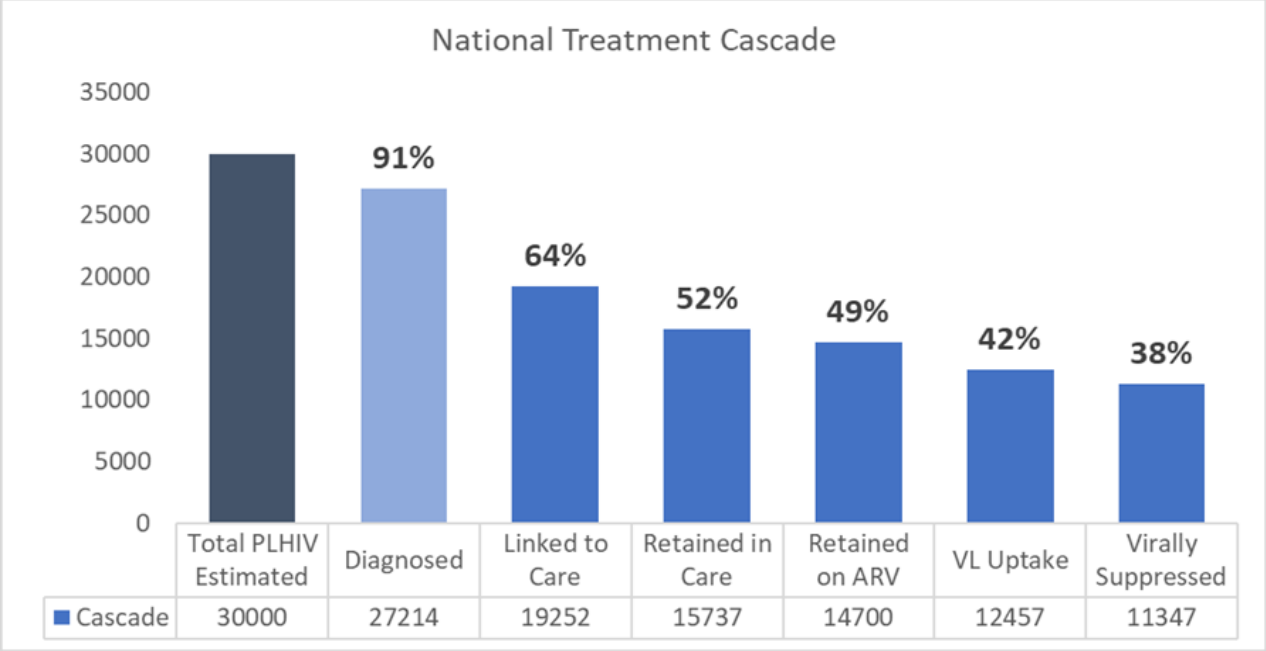


Figure 4: National Treatment Cascade, 2022

Vaccine preventable Diseases

Though Jamaica has not had a breakout of any of the conditions covered under the country's vaccination schedule, the decline in the vaccination rates for all the antigens is a source of concern.

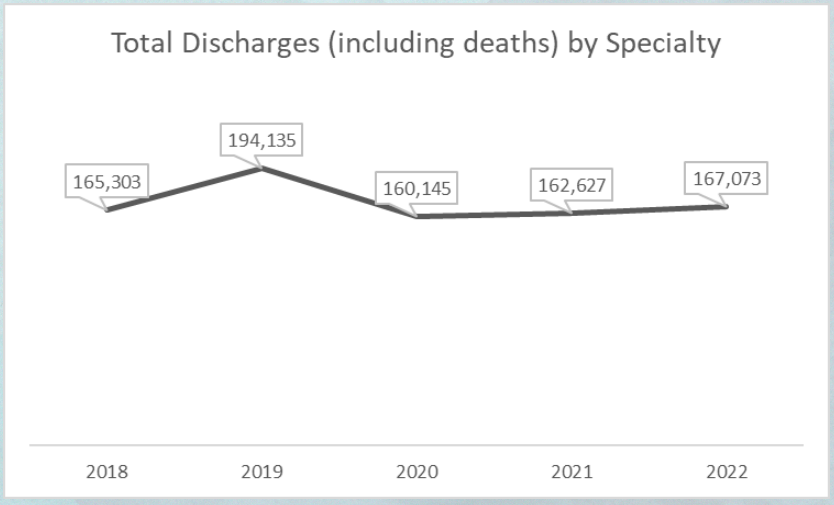
*Table 5: Immunization Coverage 2017-2021**

Vaccines	2017	2018	2019	2020	2021
BCG	93%	94%	95%	99%	97%
Polio3	92%	98%	94%	95%	90%
DPT3	92%	98%	94%	95%	90%
Hib3	93%	98%	94%	95%	90%
HepB 3	92%	98%	94%	95%	90%
MMR 1	95%	93%	94%	93%	88%
MMR 2	94%	86%	93%	86%	85%

Health Service Utilisation

There was a slight increase in discharges from 2021 to 2022 with the highest recorded discharge figure in 2019 of 194,135 patients.

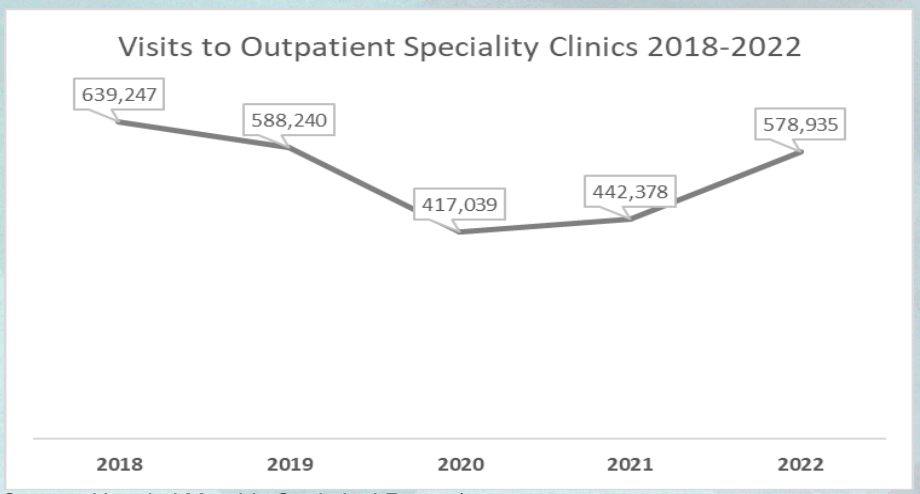
Figure 5: Total Discharges by Specialty 2018 - 2022



Source: Hospital Monthly Statistical Report*
*** data are provisional

There was a significant increase in the number of patient visits to outpatient speciality clinics from 2021 to 2022 (24%). The highest recorded total was 639,247 patients in 2018.

Figure 6. Visits to Outpatient Speciality Clinics 2018-2022*

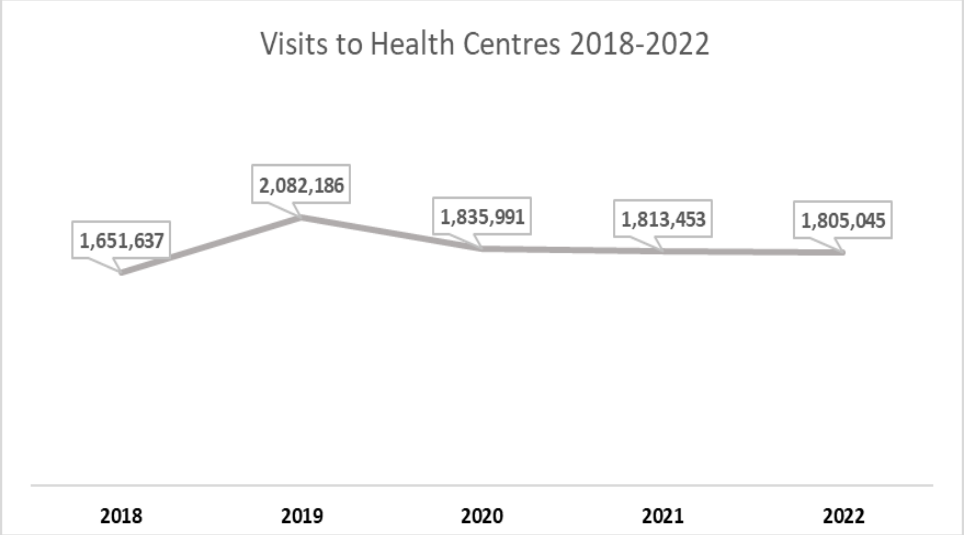


Source: Hospital Monthly Statistical Report*

*data are provisional

Visits to health centres

Figure 7: Visits to Health Centres*



Source: Hospital Monthly Statistical Report*
*data are provisional

The health centre visits have recorded marginal but consistent declines since 2019. It is not clear whether this decline is the result of absolute demand for services or the result of a shift in the demand to "substitute" health centre visits with visits to accident and emergency departments in hospitals. Regardless of the reason, this trend is important as the future considerations for the modality and model of primary care in Jamaica is contemplated.

Chapter Three: Health Spending Situational Analysis

Jamaica's public health sector is currently mainly financed from the following four sources:

- ✓ Government taxes,
- ✓ Out of pocket payments,
- ✓ Pre-paid plans/health insurance,
- ✓ External aid and support.

The share of health financing is split between government (GHE) and private (PHE) sources, averaging 65% and 45% respectively over the decade not unlike the global trend of 60% and 40% respectively.

The table below shows Jamaica's performance in relation to the health financing indicators over the last 10 years.

Table 6: Key Health Expenditure Indicators 2011-2020

Indicators	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
CHE as%GDP	5.2	4.9	5.0	5.2	5.6	5.7	6.1	6.0	6.1	6.6
CHE per capita	275.5	262.1	254.8	257.8	285.6	286.3	324.2	333.9	343.1	325.7
Domestic General Health Expenditure in USD million	447.3	412.0	424.0	425.5	505.0	510.4	602.0	611.7	629.8	624.7
Domestic Private Health Expenditure	292.2	287.9	275.6	282.3	281.9	279.5	295.5	313.0	320.1	280.0

Indicators	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Domestic Health Insurance DOM%CHE	97.7	96.8	99.0	98.6	98.6	98.4	98.6	98.5	98.4	98.5
GGHE-D % Current Health Expenditure	59.1	57.0	60.0	59.3	63.3	63.6	66.1	65.2	65.2	68.0
Domestic Private Health Expenditure %CHE	38.6	39.8	39.0	39.3	35.3	34.8	32.5	33.3	33.2	30.5
Out of Pocket % CHE	22.0	21.8	19.5	21.4	19.0	17.9	16.8	16.8	16.4	15.1
GGHE-D %GDP	3.1	2.8	3.0	3.1	3.6	3.6	4.1	3.9	4.0	4.5
GGHE-D% General Gov Expenditure GGE	9.5	9.2	10.8	11.3	12.8	12.7	14.0	13.0	13.3	14.0
GGHE-D per capita in US$	162.9	149.3	152.9	152.8	180.7	182.1	214.4	217.6	223.8	221.5
OOP per capita in US$	60.7	57.0	49.6	55.2	54.2	51.3	54.3	56.0	56.4	49.1[BK1]

Out-of-Pocket Payments (OOP)

The Jamaican health system typifies those of the Caribbean with a mix of public and private entities both in regards to the provision and financing of health services. With very limited access to the financial protection in the private health sector, there is a considerable amount expended in out-of-pocket (OOP) payment

by the uninsured and co-payment for the insured users in Jamaica for the purchase of healthcare services outside of the public health sector. International evidence reveals that when OOP expenditure is above 20%, families are at a greater risk of catastrophic health spending [4]and impoverishment resulting from an episode of illness. In recent years, however, OOP has fallen below that threshold in Jamaica. It is still unclear if this downward trend in OOP is the result of improved financial protection of if it is impacted by suppressed demand for health care. The utilization rates in the public sector does not reflect a significantly increasing demand in the public sector.

Private health insurance

Private health insurance constitutes the third largest source of health care expenditure in Jamaica. Based on the 2015 Jamaica Survey of Living Conditions (JSLC) approximately 19% of the population have private health insurance – more than half of these are public sector workers - with the largest proportion of those with health insurance being in Quintile 5 (40.3 per cent) and lowest being in Quintile 1, 3.7% . The lack of insurance means that too many people, including the poor and vulnerable, are denied access to timely medical care. In 2016, 32% of Jamaicans reported that they did not access care when needed due to financial reasons, while World Bank data (2011) reveals that the average Jamaican with a NCD allocates a third of his/her monthly household income to health care. All compounded, these have caused challenges for low income groups. Inadequate pooling and financial protection means that the at risk populations for 'catastrophic' and 'impoverishing' health payments is very probable given the World Bank estimated 29% and 21% respective likelihood.

[4] Catastrophic Health spending defined as an expense which is more than 40% of an individual's capacity to pay.

Health Spending Global comparison

Current health expenditure (CHE) as a share of GDP provides an indication of the level of resources channeled to health relative to other uses. For the past ten years Jamaica average CHE as a percent of GDP was 5.64. In 2012 the lowest percentage was experienced at 4.89 % and in 2020 the highest of 6.61%.

The table bellows shows a ten year average and current CHE %GDP for countries within the Caribbean and developed countries with different methods of health system financing.

Table 7: Ten-Year Average Health spending as a percentage of GDP for Jamaica compared to select countries

Countries	10 years average % of GDP	CHE%GDP 2020
Argentina	9.73	9.98
Bahamas	5.87	7.59
Barbados	6.92	7.20
Canada	10.90	12.94
Jamaica	5.64	6.61
Trinidad	7.32	6.02
USA	16.66	18.82
UK	10.00	11.97

Jamaica's per capita spending on health in 2020 was US$325.72. This represents an increase of 18.21% over the past ten years. In 2011 per capita spending on health was US$275.54. The average per capita health spending in 2020 for Bahamas, Barbados, Trinidad and Tobago and Jamaica was US$1101.79, Jamaica had the lowest per capita health spending of all these nation states. The WHO states that government health expenditure per capita has doubled since the year 2000. The aim of increasing government spending on health is to reduce the amount of out of pocket spending by citizen which can cause economic hardship and push households into poverty.

Out of pocket as a percentage of current health expenditure was 15.1 for Jamaica in 2020, while private health expenditure as percentage current health expenditure was 30.5%. Domestic General Government Health Expenditure (GGHE-D) as % Current Health Expenditure (CHE) in 2020 for Jamaica was 68%. This level of spending represents a 15.3% increase since 2011, when spending was 59.1%. Public sources include domestic revenue as internal transfers and grants, transfers, subsidies to voluntary health insurance beneficiaries.

Budget versus Forecasted Health Expenditure

In 2018, as part of the Ministry's process to develop a Ten Year Strategic Plan, an exercise was undertaken to conceptualize an Essential Health Benefit Package for Jamaica. The cost of this conceptual Essential Health Benefits Package was estimated to cost approximately $468.2 billion by 2035. Investments in primary care, maternal and child care, and health promotion and disease prevention account for 18.4 percent of total spending. On their own, promotion and prevention represent about 1.8 percent of the total. Discharges, emergencies, and pharmaceuticals account for 44.3 percent of total spending. Table 8 below outlines the chronology of the projected health spending needs over a fifteen year timeline broken down in the first and second instances, into five year and ten year intervals.

Table 8: Projected Healthcare Spending in '000 millions 2020-2035

Category	2020	2025	2035
Imaging	562.9	852.3	1,908.9
Home visits	378.9	573.7	1,285.1
P&P	2,309.9	3,273.7	8,551.2
Lab exams	5.853.7	8,863.6	19,852.6
Outpatient	6,553.4	9,923.0	22,225.4
Primary Care	14,853.8	22,491.3	50,375.7
NHF Benefits	2,531.3	3,395.8	5,970.6
Capital and Maintenance	8,038.7	12,172.1	27,262.8
Surgeries	1,088.7	1,648.5	3,692.3
MCH	7,068.1	10,936.9	26,166.6
Mental health and Rehab	3,381.5	12,732.0	54,073.9
Administrative	7,172.8	15,215.1	34,078.5
Discharges	18,316.0	38,851.9	87,020.1
Emergencies	18,157.7	38,516.2	86,268.2
Pharmaceuticals	8,063.8	16,867.9	39,515.5
Total public	127,405.1	196,614.7	468,247.4

Source IOS Consultant report 2018

By 2020, mental health costs is projected to be approximately $3.4 billion, the budgetary allocation in 2020/2021 for this area was $1.9 billion, this represents a $1.5 billion difference between estimated cost of care and government funding. The Government of Jamaica would have had to increase their spending on Mental Health by 77.5% to reach spending levels indicated within the report for 2020. The amount allocated to Bellevue Hospital - the island's only mental health hospital - was $2.02 billion in 2023, yet again this amount is $10.7 billion less than the projected need in 2025 while only a few years away.

Total spending for Primary Care was modelled to be at $14.9 billion, $22.5 billion and $50.4 billion for 2020, 2025 and 2035 respectively. In 2020/21, submission of spending disaggregated by primary and secondary care for the Regional Health Authorities showed total primary care spending was $14.9 billion. Although the amount was in line with the estimates of 2020, by 2025 an increase of 51.4% is

needed to reach the projected cost for that year, and an increase of 239.1% to grow to the 2035 cost projections.

Pharmaceutical spending was forecasted to be $8.1 billion in 2020, $16.9 billion 2025 and $39.5 billion in 2035. The proposed pharmaceutical contract awards for the period 2023-2026 is valued at J$27.59 Billion. National Health Fund's (NHF) budget for fiscal year 2023/2024 for individual claims is estimated to be approximately J$8.7billion while the operational cost for the Pharmacy programme is forecasted at J$12.4 billion. NHF benefits were projected to be $2.5 billion, $3.4 billion and $6 billion for 2020, 2025 and 2035 respectively while spending for 2020/2021 as it relates total individual benefits was actually $5.9 billion.

Estimated capital spending for 2020 was $8.0 billion dollars, $12.2 billion in 2025 and $27.3 in billion 2035. According to figures taken from the 2022/23 budget $1.5 billion would be spent on capital projects. However, according to the Capital expenditure report for 2019-2024, total spending for this four year period was $27.2 - $31.2 billion. This quantity is $3.9 billion more than projection for the next 10 years as provided by the model.

Capital expenditure as reported by the NHF for 2020/2021 was $125.46 million on infrastructure and $7.99 million on medical and non-medical equipment.

When the current Enhancing Health Care Services Delivery (EHCSD) Program is considered, the provision of diagnostic services for health conditions in 2020/2021 was JM$710.9 million and $1.8 billion in 2022/2023. A comparison of projected cost for the provision of the same service by the Consultant revealed $562.9 million in 2020 and $852.3 million in 2025 and $1.9 billion in 2035. The government has outstripped the approximate spending for 2025 as presented in the Consultant by

$928 million and this difference is possibly greater as the cost of diagnostic services undertaken by the public hospitals are not included for an overall total.

Lab figures as modeled are $5.9 billion in 2020 while the budgeted amount for that year was $1.4billion, in 2025 $8.9 billion, while budget approximation was $1.7billion for 2025/2026. In 2035 the Consultant's estimate was $19.9 billion, a 1100 % increase would be needed to move the Ministries estimate of $1.7 billion in 2025 to reach this target, a difference of $18.2 billion.

Whereas discharges and pharmaceuticals are expected to decline, emergencies are expected to increase, thereby offsetting the decrease in discharges and pharmaceuticals.

Mental health services and rehabilitation would have more than tripled their allotment in the 2016-2035 period, moving from 2.6 percent to 11.5 percent out of total nominal public cost. Laboratory and imaging services tend to stabilize at around 5 percent of the total cost during the period.
The exercise also summarized the financial needs related specifically to the introduction of the essential benefit package.

Table 9: Financial gaps broken down by inputs for provision of Essential Package

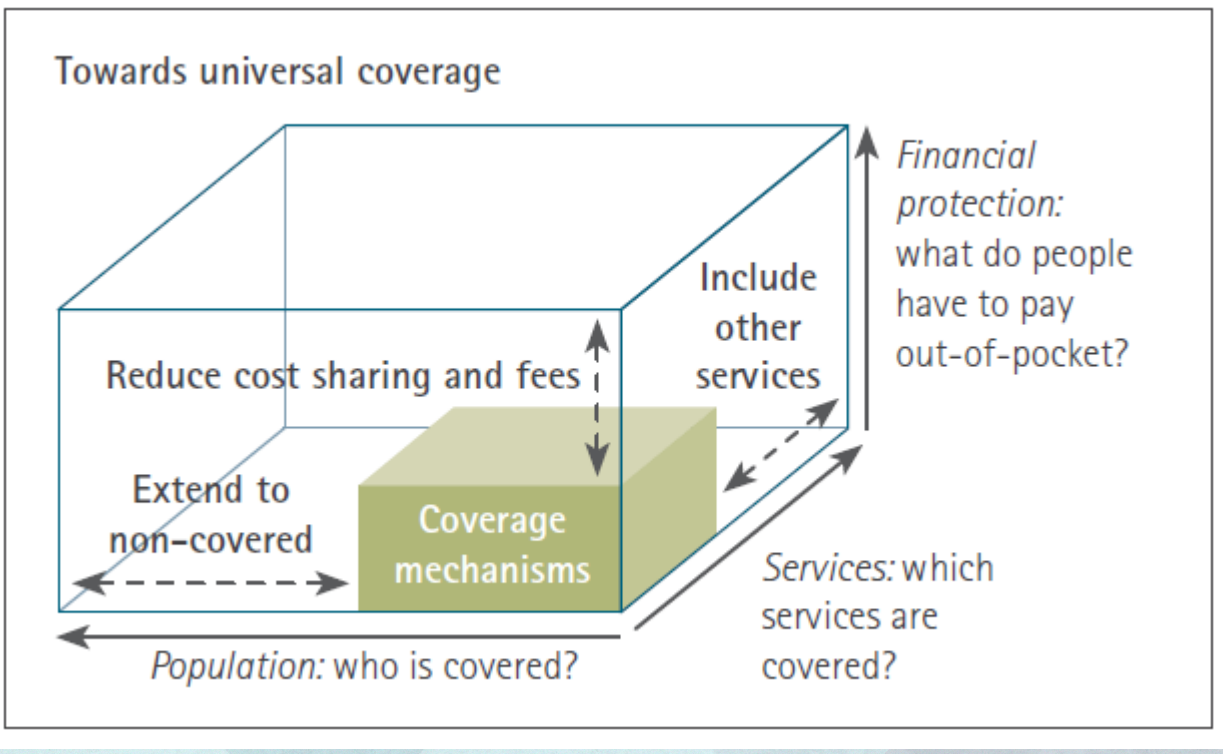
Plan activity/component:	USD(million)	JMD$(million)
Annual Cost of Essential Benefit package (financial gap)	US$50.1	6,273.4
Additional staff requirements (financial gap)	US$69.7	JM$ 8,712.7
Cost of Upgrading Equipment for the Restructured Health Centres	US$115.1	JM$14,387.5
Cost of Infrastructure Works to Upgrade Health Centres	US$96.3	JM$12,037.5

Chapter Four: Universal Health Coverage

Universal Health Coverage (UHC) is firmly based on the 1948 WHO Constitution, which declares health as a fundamental human right and commits to ensuring the highest attainable level of health for all. It specifically states that *"Universal health coverage means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care"*.

The UHC cube shown below is a framework for understanding the key dimensions of UHC and how they relate to each other. The cube has three dimensions: population coverage, service coverage, and financial protection.

Figure 8: Universal Health Coverage Three Dimensions Cube



Population coverage refers to the proportion of the population that is covered by health services. Service coverage refers to the range of health services that are available to people. Financial protection refers to the extent to which people are protected from financial hardship due to health care costs.

Progress towards UHC

Achieving UHC is one of the targets the nations of the world set when they adopted the 2030 Sustainable Development Goals (SDGs) in 2015. Countries reiterated during the 2019 United Nations General Assembly High Level Meeting on UHC that health is a precondition for, a result of, and an indicator of the social, economic, and environmental components of sustainable development.

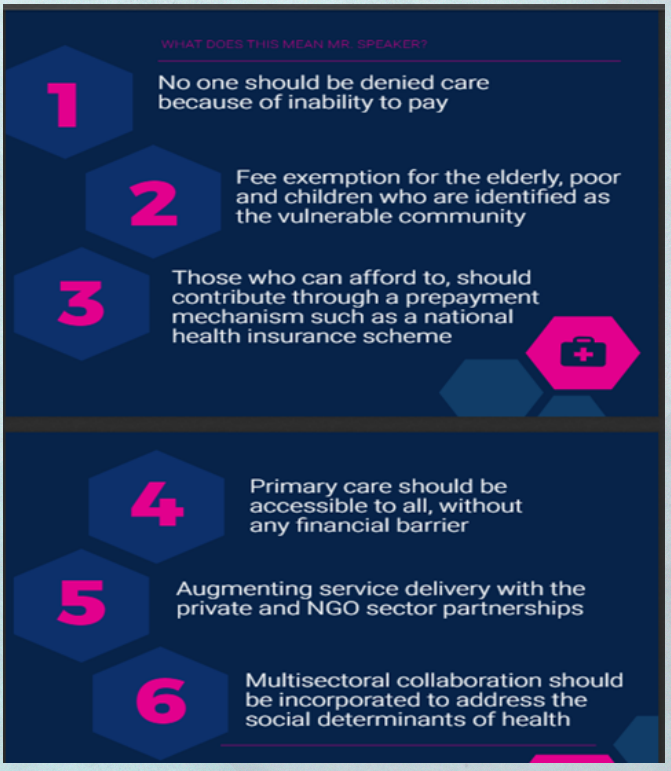
Prior to the COVID-19 pandemic, there had been significant progress toward UHC. The UHC service coverage index (SDG indicator 3.8.1) increased from 45 in 2000 to 67 in 2019, with the WHO African Region experiencing the fastest growth. However, 2 billion people face catastrophic or impoverishing health-care costs (SDG indicator 3.8.2). Based on the WHO, Jamaica moved from 36.96 in 2000 to 70.11 in 2019 on the UHC service coverage index (SDG indicator 3.8.1).

What is Universal Health Coverage within the Jamaican context?

The figure below provides a centre-piece for a national consultation process in order to craft a perspective of UHC that is most relevant to Jamaica.

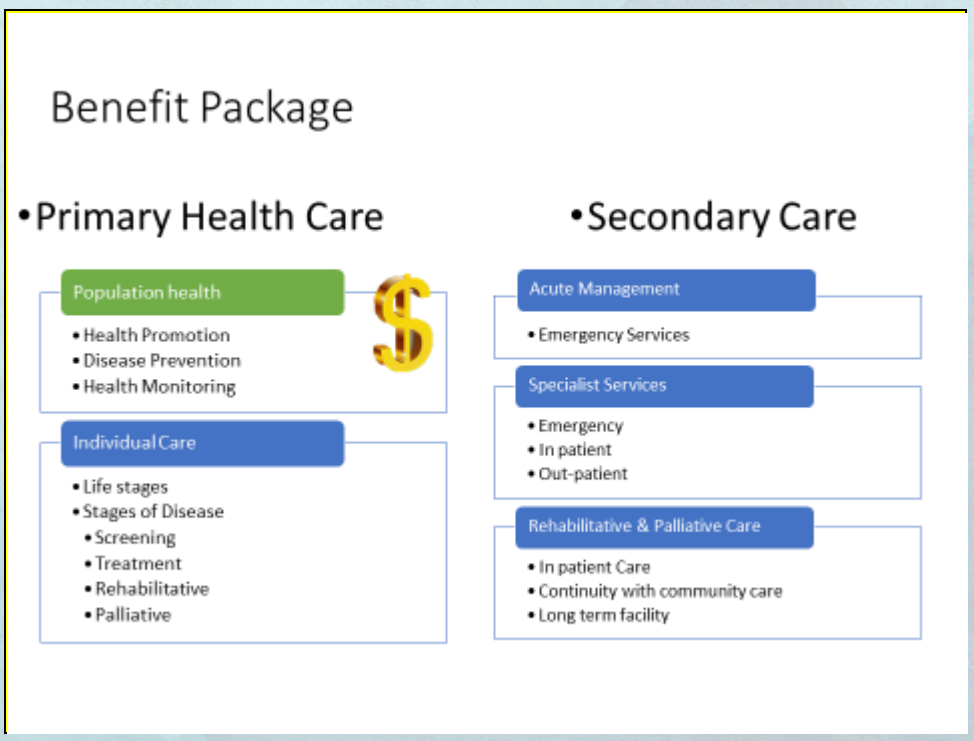
- ✓ For the ethical point #3 - how to determine who to pay and how to pay for health care
- ✓ For ethical point #5 - how much service should be purchased from the private sector. How much proclivity is there to extend social protection to and solidarity into the private sector represent matters that will require robust discussions at various levels of society.

Figure 9: Jamaicans Perspective Towards Universal Health Coverage



Even with the definition of a benefit package there has to be the tiered discussion about how much of a product and service should be provided. Another discussion would be whether it was provided by public or private facility or a combination of both.

Figure 10: Deconstructing the Benefit Package



Summary of the expectations and value of engaging in the process to determine the most suitable benefit package for Jamaica (Appendix 1 outlines the preliminary listing):

- Best value for money
- Expect Equity, Accountability, Improved Efficiency, Political Empowerment
- Represents Guaranteed minimum
- Poor Country : Limited list mainly Primary Care/ some Secondary Care
- Rich: " Anything you like"
- Promote Equity
- Implementation : MUST have stakeholder consultation, Buy-in of Providers otherwise will not succeed
- MUST have "Supports": Budgetary Allocations, Essential medicines list, necessary Staff with Skills set, deployment of skills set

On the matter of the private sector, a clear delineation of their role would be required even as the government elaborates its own health plans. In this regard, the private providers and private health insurance companies can be considered in the following ways:

- Offering packages that are supplemental to the proposed GOJ plan to cover services that are not included in the NHIP benefit package;
- Covering out of pocket payments that may not be included in the GOJ coverage, e.g. covering branded pharmaceuticals where only generics are included;
- Providing coverage for utilisation levels that exceed the limits on GOJ, such as non-medically necessary additional ultrasounds for uncomplicated pregnancies, etc.
- Offering packages that provide for overseas care.

In order to progress with the implementation of UHC in Jamaica there has to be a comprehensive dialogue surrounding the following pivotal design specifications for how the system would be developed in Jamaica:

- Unit of Payment - is it for service provided or outcome, or for a population group
- Direct vs. Indirect payment - user fees or taxation or contribution to a plan
- Prospective vs. Retrospective payment- pre-payment or post-payment
- Incentives for Behaviour of Providers (often neglected in the scheme of considerations)
- Payer/provider or separate – The role of the regulator, the service providers and the payers should be must be clearly delineated and agreed upon

Chapter Five: Major Policy Decisions for Universal Health Coverage

Primary Health Care Reform

Redesigning the Health System in Jamaica was described by Goffe and McCartney from as early as 2004, with several subsequent revisions[5]. This led to a proposal for Primary Care Renewal which was approved by Cabinet in 2016 and paved the way for significant changes in the system. The modifications feature improving infrastructure and augmenting human resources, revamping the structure of health centres, and adopting an integrated and patient-centric model of care. The proposed structural reform therefore points to restructuring of the service delivery system with significant upgrading of general standards to allow for higher efficiency and quality in primary health care service delivery with improved diagnostic services leading to higher utilization of the primary health care facilities.

As mentioned previously, the proposed revised primary care service delivery system will consist of three main categories of Health Centres replaces the existing 5 categories with three categories:

- The three revised primary care institutions will be the following:
- Community Health Centres
- District Health Centres
- Comprehensive Health Centres

In densely populated urban areas the proposed Comprehensive Health Centres will provide additional coverage as Urban Comprehensive Health Centres.

It is imperative to enhance and make the primary health care system more adaptive and efficient to facilitate the evolving demands for health services in the population. The

[5] Goffe & McCartney (2007). Redesigning the Health System in Jamaica: A Proposal

proposed Primary Health Care Reform 2021-2030 discussion document presents the vision for health care as Jamaica accelerates progress toward universal health coverage.

National Health Fund

The establishment of the National Health Fund (NHF) in 2003, was another step taken by the Government to improve access to health care. The NHF provides financial support to the Jamaican health care system to enhance its efficacy and the wellbeing of the citizens. It may be considered the most significant reform in the health financing system of Jamaica since independence (Lalta, 2016). In design and conception, the NHF was determined to be the first phase in implementation of a full-fledged National Health Insurance[6].

In 2011, the NHF Act was amended and the NHF assumed the functions of Health Corporation Limited (HCL). Since 2018, NHF has full responsibility for the provision of pharmacy services to the public sector as described in the Service Level Agreement between the Ministry of Health and Wellness, NHF, RHAs and Bellevue Hospital. This agreement pertains to the financing, management, procurement, warehousing, and distribution of VEN Lists pharmaceuticals and medical sundries to public health facilities. Additionally, it covers the provision of professional pharmacy services to the RHAs and Bellevue.

Since its inception the NHF has provided significant benefits to the 345,000 active beneficiaries as of December 2022 and a total subsidy of approximately $58.7 billion spent in subsidies to its members. Total membership at that time 741,000 with 4.3 billion claims processed in 2021/22 compared to 3.1 billion claims in 2012/13 translating to $6.4 billion and $3 billion for the respective period. In keeping with the NCD surge five health conditions accounted for 78 percent of total subsidy payment – diabetes (30%), hypertension (24%), high cholesterol (11.3%), prostate cancer (7%) and glaucoma (6%).

[6] Barrett & Lalta (2004). Health Financing Innovations in the Caribbean: EHPO and the Nation Health Fund of Jamaica.

The Ministry of Health and Wellness is faced with a few options, namely: reducing benefits to Jamaicans who cannot afford to pay for medicines or curative services in the private sector, implementing a more sustainable funding model for the health sector, or implementing policies and laws to promote a healthier lifestyle and reduce costs. It is likely that a combination of these options will be the solution. The reality is that healthcare costs are increasing rapidly and financing is necessary for access.

Removal of User Fees

Achieving Universal Health Coverage is a widely acknowledged global objective, and Jamaica has been pursuing it since the 1970s by eliminating out-of-pocket payments to facilitate greater accessibility to healthcare services[7]. In 2008, fees were abolished for all public patients but retained for public patients with insurance, private patients and foreigners. There is however considerable leakage as individuals are often unwilling to identify themselves as insured, there are also anecdotal accounts that the staff are not requesting the information of them for the purpose of generating a bill.

Green Paper: National Health Insurance Plan

Tabled in 2019, the latest iteration of a proposed national health insurance plan was built out from the NCD "Best Buy" options developed by the WHO as a guide for the most cost-effective interventions low- and middle-income countries. In addition it was designed to be available to everyone and intended to provide an affordable alternative to private health insurance while promoting competition in the health insurance market for individuals and household wishing to purchase more private insurance packages.

Current Outsourcing Initiatives

Currently, the health sector is experiencing a shift in demand due to various factors such as rising life expectancy, the emergence of new diseases, a surge in chronic illnesses, and lack of updated infrastructure and equipment. Despite this, the Ministry is committed to making investments in the well-being of all residents and ensuring that health care

[7] Ministry of Health & Wellness (2019). Green Paper on National Health Insurance Plan for Jamaica.

services are accessible. To that end, several outsourcing projects have been established. The Enhancing Health Care Services Delivery Project aims to increase access to elective care treatment, timely diagnostic services and reduce wait times for patients in emergency departments. This project includes a component where patients receive diagnostic services from approved private service providers.

The Public Private Partnership for Non-communicable Diseases (PPP4NCDs) Programme, a shared-care initiative, was launched by the MOHW in November 2020 during the COVID-19 pandemic as an alternate arrangement for the expansion of health services, recognizing the significant resource constraints in the public health system. Approved general practitioners (GPs) in the community are engaged by the Ministry to provide clinical care for clients with diabetes and hypertension seen at public health centres and maintain essential services for these clients. GPs are remunerated at a cost of $4,000 per visit with a maximum of 6 visits per client per year. The programme pilot commenced in July 2021 in the parishes of St. Ann, Clarendon and Kingston & St Andrew (KSA) with four (4) contracted GPs and six (6) referring health centres. Nine (9) additional GPs and seven (7) additional health centres in Westmoreland, St Catherine, St. Ann and KSA were added in February 2022. Canopy Insurance Limited was engaged in March 2022 to adjudicate GP claims for patient visits. As at January 10 2023, a total of 653 patients have been enrolled across the island.

Chapter Six: Achieving Sustainable Financing of Universal Health Coverage in Jamaica

There has been a considerable amount of studies conducted about Jamaica regarding health financing. In his analysis Lalta (2016) categorized the main health financing proposals in these reports as 'a mix of primary 'strongly recommended' and supplementary 'recommended' measures, to be implemented separately or in combination'. Among the primary measures 'strongly recommended' were:

- Increasing the range and magnitude of user fees for government health services (4 reports);
- Increasing levels of private health insurance coverage through appropriate incentives (5 reports);
- Introduction of a mandatory contribution-based social/national health insurance (S/NHI) program (13 reports);

The NCD Alliance's recommendations to low and low middle income countries (LMICs) for financial support to NCD management and control are all worthy of consideration. These innovative financing mechanism is summarised in three categories:

- Voluntary contributions. Voluntary contributions have included credit card rounding plans, lotteries and cause-related marketing schemes.
- Compulsory levies or taxes. These exist both at the national level with the introduction of excise taxes
- To curb consumption of unhealthy products, and also at the international level with initiatives that aim to expand on the idea of the UNITAID airline tax scheme.
- Financing mechanisms. This category may include global institutional mechanisms, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria; the GAVI Alliance; or local institutional arrangements, such as microfinance. It can also include international borrowing, and public–private financing arrangements, such as the Global Financing Facility.
-

Wither User Fees

The government increased the health budget by approximately 3 billion JMD in the first year to replace the user fees that were foregone. Most of this budget (over 80 percent) comes from taxes and, through the Ministry of Health and Wellness, is transferred to Regional Health Authorities and UHWI for health service provision. It has been observed that:

- The removal of user fees in RHA-managed public facilities correlated with a 10 percent increase in the use of health facilities by the poorest 20 percent of the population;
- The increase in the budget has not been sufficient to fund the demand for services;
- With the presence of a robust for-profit private health sector it would not be possible to eliminate OOP and users will encounter financial barriers when the seek care there.

Alternatives to User Fees

According to an article on the British Journal of General Practice website, there are alternative models to mandatory user fees in healthcare. One such model is offering an affordable voluntary insurance entitling patients to extended services while standard services remain accessible to most people. Another alternative is incentivizing healthier lifestyles in parallel to 'sin taxes' on undesired behaviors such as smoking or sugar and alcohol consumption[1].

Countries not wishing to apply tax revenues to counter the exclusion caused by user fees, cn consider two broad alternatives to user fees at the local level. One alternative is to exempt from payment those who are permanently excluded from health care because they are too poor. The other is pre-payment schemes, where people are asked to pay before they need services. Community-based health insurance (CBHI) systems can be considered as one of these pre-payment modalities[2].

Table 10: to Progression of Nation Health insurance 1965-2003

Year	Key Proposal	Reasons for Non-Action
1945	British West India (Moyne) Commission Report—Partial Social Health Insurance for Formal Sector Workers (as with NHI in UK at that time)	>High cost of administration given dispersed population >Inadequate size of pool >Weak post-war economy
1960's	Official debates on National Insurance Scheme---Add health component to NIS	>Large informal sector >Absence of 'pre-paid' culture >Too large deduction needed
1974	Green Paper on National Health System—Integral role for contributory health insurance scheme	>'Free care' already on 'democratic socialism' agenda >High public investment in health sector >Housing assigned higher policy priority
1980's	Mixed Proposals largely giving major role to private insurers to manage S/NHI for selected groups	>Coverage of poor and informal sector >Ongoing macroeconomic constraints >Components of benefit package
1997	Green Paper on NHI for Jamaica—Mandatory plan for all to be managed by public and private insurers	>Components of benefit package >Ongoing macroeconomic constraints > Service delivery capacity of health sector
2003	National Health Fund—as early phase of NHI	>Service delivery issues with public sector >Ongoing macroeconomic constraints >Cost of package and size of deductions.

Once again the discussion is back on the table with the 2019 tabling of another green paper with consultation being interrupted owing to the COVID pandemic. A national discussion on health insurance would address the involvement of the private sector in order to augment the points of delivery in the healthcare system to address long waiting time and overcrowding especially.

What are the possible options?

According to the World Health Organization, there are several global health financing systems. These include tax-based financing, social health insurance, community-based health insurance and private health insurance.

Examples of tax-based financing[8] include the National Health Service in the United Kingdom and the Ministry of Health in Brazil. Examples of social health insurance include the National Health Insurance Scheme in Ghana and the National Health Insurance in Germany. Examples of community-based health insurance include the Mutuelles in Rwanda and the Community Health Fund in Tanzania.

[8] A tax-based health system is a health financing system in which government revenues are the predominant source for health care expenditures[1]. It is a system where more than half of public expenditure is financed through revenues other than earmarked payroll taxes[1]. In this system, access to publicly-financed services is open to all citizens. (WHO)

Chapter Seven: Future Proofing the Health Care System (Health System Resilience)

Undoubtedly, the global community has enjoyed several decades of improvements in overall health outcomes with recent decades showing substantial increase in health spending However, as one writer warned that blind spots persisted, and these blind spots posed substantial risks to human health and economic well-being; and even had the potential to undo recent progress.

These blind spots include: systems unable to effectively respond to pandemics such as influenza and outbreaks of communicable diseases like COVID-19; health system structures unfit to cope with the rapidly increasing prevalence of non-communicable diseases (NCDs); threats posed by the AMR and other evolving diseases; and the complex health impacts of large population movements, environmental degradation and climate change. Additionally, there is the epidemic of violence and trauma resulting in increased deaths and disability and the ripple effect of economic underachievement.

Small island states such as Jamaica, face a number of common challenges. They are especially vulnerable to climate change and extreme weather events and have limited capacity and human resources to respond to certain health challenges. Since COVID the international community is now more focused on health security safeguards and on building resilient health systems.

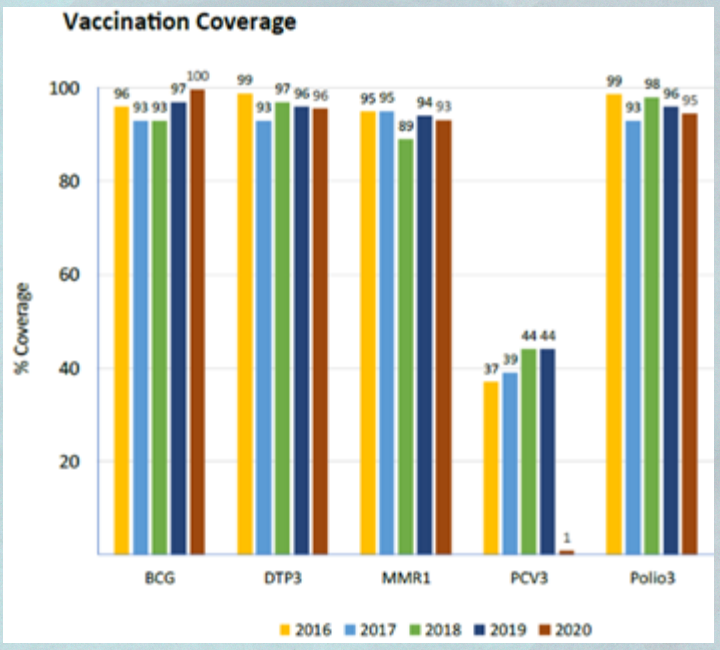
In Jamaica the threats to the health system are from new and emerging infectious diseases, aging population, health lifestyles leading to burgeoning chronic non-communicable diseases, natural disasters and having one of the highest rates of violent crimes as well as trauma from motor vehicle crashes. The problems are very acute with the country having one of the highest murder rates, high obesity problems and considered to be among the most prone to natural disasters. Finally, the fast growing viral infection –

dengue – is endemic in 100 countries including Jamaica but is indicative of the country being prone to mosquito borne diseases in particular.

Increased country capacity to develop and implement comprehensive plans, programs, or strategies for the surveillance, prevention, control, and/or elimination of neglected, tropical, and zoonotic diseases was an agreed objective of the Country Cooperation Strategy between Jamaica and PAHO signed for 2017-2022.

Strengthening the Jamaican Health System

Historically, Jamaica has had an outstanding record for immunization. The result of these high vaccination rates is herd immunity manifesting itself in zero local transmission from these vaccine-preventable pathogens (Vitals, 201).



Surveillance and International Health Regulations

International Health Regulations

A critical pillar of Jamaica's responsiveness and early detection capabilities is contained in the measure of the country's progress in implementing the international health regulations (IHR). The IHR places obligations on Jamaica to develop certain minimum

core public health capacities. The 2020 country self-assessment revealed that Jamaica was performing at higher than the global average for all the core competencies.

Border control agencies, such as the Passport Immigration and Citizenship Agency (PICA) and Jamaica Customs Agency (JCA) also form a part of the IHR Stakeholder working group, and these entities are responsible to ensure that all persons entering the island are properly screened.

In its response and preparedness network, the Health Ministry also works closely with the Jamaica Fire Brigade, Jamaica Defence Force, Jamaica Constabulary Force, the Office of Disaster Preparedness and Emergency Management and other agencies to ensure that in the event that there is a need to respond to a radiation or chemical emergency, this can be done in a timely, responsive and all-inclusive manner. In 2017, the country's emergency management agency (ODPEM) prepared its first chemical emergency management plan.

Surveillance

Jamaica is part of a global network that focuses on respiratory viruses World Health Organization's (WHO's) Global Influenza Surveillance and Response System (GISRS). Its primary objective is to monitor the changes in the influenza viruses over time and guide the production of influenza vaccines each year (Vitals, 2018). The Government of Jamaica, Ministry of Health, is in receipt of a five (5) year grant from the Centers for Disease Control and Prevention (CDC) for the "Surveillance and Response to Avian and Pandemic Influenza in Jamaica" the publication also highlighted. The global health security index (GSHI) scored Jamaica lowly for pandemic planning outside of an influenza pandemic and for being outstanding in implementing antimicrobial resistance (AMR) surveillance.

Violence and Trauma

Proponents of the violence and trauma as a public health issue maintain that it can be approached through the scientific method as outlined in the figure below.

Supporters of such a view maintain that public health draws on a multi-disciplinary scientific base, drawing on knowledge from a range of disciplines including medicine, epidemiology, sociology, psychology, criminology, education, and economics (CDC website). Violence can also be transmitted across generations and across different forms of violence, such as interpersonal violence, self-harm, domestic violence, and community violence[3].

To address violence as a public health matter, a comprehensive and coordinated approach is needed that involves multiple sectors and stakeholders. One framework that can guide this approach is the public health approach to violence prevention, which consists of four steps[2] outlined in the following image. Some examples of prevention strategies that have been shown to be effective or promising in reducing violence include: Strengthening individual skills and resilience through social-emotional learning programs, parenting programs, life skills training, and cognitive-behavioral therapy.

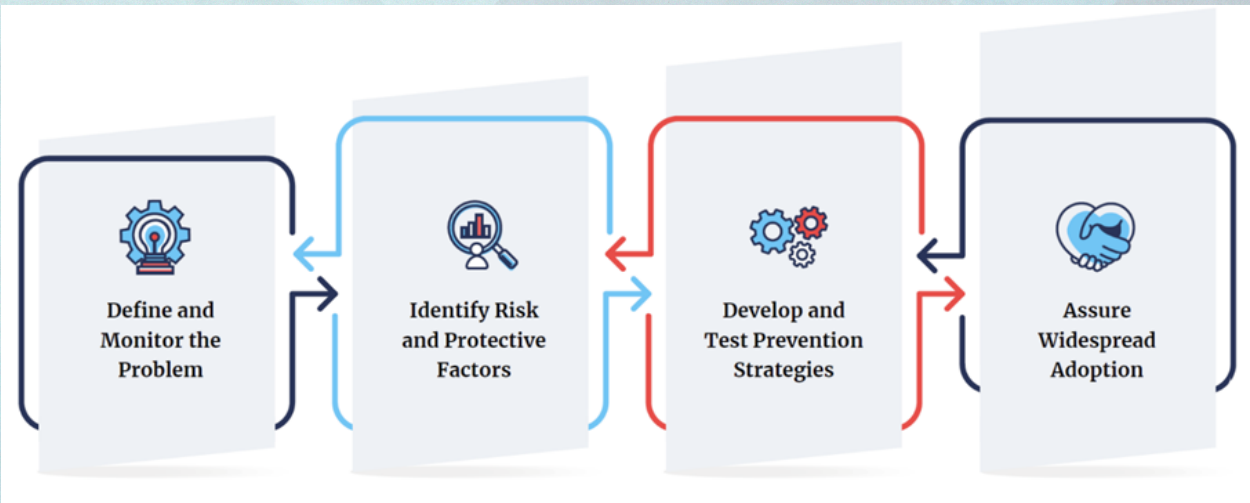
Promoting positive relationships and norms through mentoring programs, bystander interventions, school-based programs to prevent bullying and dating violence, and media campaigns to raise awareness and change attitudes.

Creating safe and supportive environments through environmental design, community mobilization, conflict mediation, restorative justice practices, and access to social services.

Reducing access to lethal means through firearm regulation, safe storage practices, and suicide prevention hotlines.

Improving data collection and surveillance systems through standardized definitions, indicators, sources, methods, and platforms for measuring violence and its impacts.

Figure 11: Steps in the Public Health Approach to Violence



Source: CDC

These are some general recommendations on how to address violence as a public health matter. However, each context may require different approaches depending on the specific types and causes of violence. Therefore, it is important to involve local stakeholders in the planning, implementation, and evaluation of prevention strategies. It is also important to address the root causes of violence such as poverty, inequality, discrimination, and injustice.

Human Resources for Health

According to the Statistical Institute of Jamaica (STATIN), the density of general medical practitioners for Jamaica in 2018 was 4.39, specialist medical practitioners is 1.25, nursing professional is 11.91, and midwifery professional is 1.46 per 10,000 population – a total of 19.01. According to the World Health Organization (WHO), countries that have fewer than 23 physicians, nurses and midwives per 10 000 population fail to achieve adequate coverage for primary health-care interventions. What the WHO recommends is that the health worker density be 45 physicians, nurses and midwives per 10,000.

Recently, the Jamaican health minister suggested that the government would consider flexible contracts that would allow nurses to work in Jamaica and another jurisdiction. The gap in that professional group is the largest as the table below demonstrates that more than 700 nurses in Jamaica had left for jobs overseas since the start of the COVID-19 pandemic.

Table 11: Staffing Needs Projection 2018-2035

Category	Current level	2018		2025	
	Required	Difference	Required	Difference	
Doctors	1,322	2,881	1,559	3,256	1,934
Nurses & Midwives	4,669	5,762	1,093	6,512	1,843
Dentists	185	576	391	651	466
Pharmacists	157	288	131	326	169

Source: WHO and FIP (2015)

Based on the projected population and the level of existing staffing per category, by 2025, the required increase was 2.5, 1.4, 3.5 and 2.1 times respectively for doctors, nurses, dentists and pharmacists.

It is against this background that were the mentioned level of migration to persist then clearly the resilience of the health system would be undermined stressing the service under normal usage and buckle under a caseload surge as in an epidemic or pandemic.

NCDs Management and Control

The objectives of the loans the Government has entered into with Inter American Development Bank (IDB) will combine to develop a capacitated local system that can demonstrate the following:

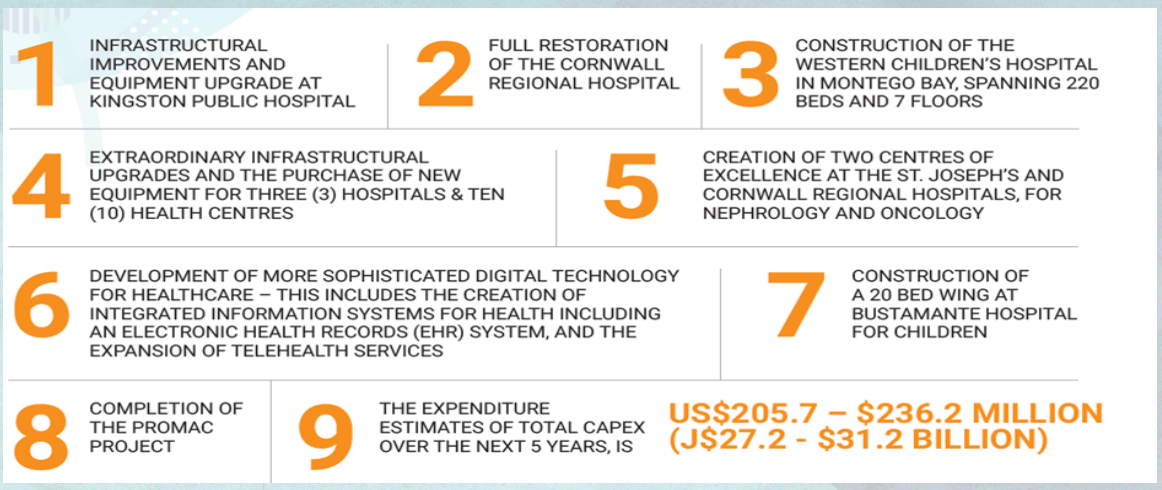
- Contribution of digital health records to patient outcome and quality of care
- Use of remote connection technology supportive to in person visits
- Operational use of upgraded screening and treatment guidelines

Improved care management through the chronic care model the continued strengthening of the integrated health network approach with dependable primary health care. As the NCD Alliance posits, interventions in NCD management and control represent an intervention in health system resilience.

Maintenance

World Bank (2017) identified insufficient allocation of funds for operations and maintenance of health facilities at only about 4 percent of central government health expenditure. Deferral and delays in maintenance has had a deleterious effect as now the country faces exorbitant costs for equipment replacement and major facility rehabilitation. The figure below summarizes the main infrastructural gaps to be addressed by an extraordinary capital expenditure plan by the government.

Figure 12: Outline of the Main CAPEX Investment for Health



With the majority of health facilities surpassing their useful lifetime it will be a challenge to rebuild and refurbish within the government's budget. Strategic Goal 6 of the Ministry's Vision for Health 2030, has the stated vision to *"Making Reliable and Modern Infrastructure Available for Health Service Delivery."* Under the 5-year capital expenditure the Ministry proposes to expend $27B - $31B to upgrade facilities and procure much needed technology for health care. Since the tabling of this document in parliament and the intervening pandemic of course, there is evidence of fiscal allocation of this magnitude being made by the government.

Recommendations

There are threats and risks that have financial implications and related system response mechanism which are briefly discussed below:

- Adopting the dynamic preparedness matrix that the Global Health Security Index provides and to lead the identification of investment required for health and other related sectors is a vital and necessary stop towards reforming the health financing landscape in Jamaica.
- Establishment of a body with responsibility for health security. In Jamaica there has been delays in the establishment of the Quarantine Authority which is now critical given global health security risks.
- Relaunch the national consultation towards the implementation of a National Health Insurance Scheme.
- Establish a policy on earmarking taxes for health care expenditure where the product or service is closely related to health and has marked health externalities and especially where promotive of the goal to strengthen the health system resilience.
- Expand spending on NCDs which has the double benefit of addressing health inequities and reducing vulnerabilities due to comorbidities thus improving the outcome of communicable disease outbreaks. Particular attention given to prioritising the incorporation of the WHO's NCDs "best buys".

- Financing of “common goods for health” to address system-wide strengthening and bolster the resilience of the health system.
- Prepare a costed surveillance plan for the island especially inclusive of a sentinel surveillance system for antimicrobial resistance.
- Notwithstanding above, prepare a costed screening plan for the island
- Incremental progression towards re-balancing between the spending on preventive and curative services. With the main risk being modifiable behaviour as there is a great need for significant spending in behaviour change programmes.
- Intervention at the highest level is required to address the overwhelming attrition among the key professional groups. This strategy would also include task shifting to other professional groups as well as improving conditions of work and, perks and benefits.

Chapter Eight: The Way Forward

Jamaica lacks sustainable and adequate funding for the health sector. The COVID-19 pandemic has shown the importance of having a well-funded and resilient healthcare system. This system must be able to respond to current as well as unexpected and future health catastrophes, as part of a comprehensive approach to public health and national well-being and security.

Countries like Jamaica face the twin challenges of meeting debt service and primary surplus requirements, on the one hand, and making long-term investments in public health, security and human development, on the other.

Without sustainable health financing and increased access to quality health care, more Jamaicans will experience poverty as a result of ill-health and high out-of-pocket payments. The COVID-19 pandemic has already pushed approximately 120 million people from mostly low- and middle-income countries into extreme poverty. The new global poor are much more likely (82 percent) to reside in middle-income countries (MICs) compared to 60 percent of the existing global extreme poor. Increasing health spending and achieving universal health coverage are important for keeping Jamaicans out of poverty. Health expenditures fall below the required 6 percent of GDP, making it difficult to address challenges related to the quality of health care, service delivery, and inadequate investments in human resources, primary care, and universal coverage. Solutions and strategies that can address current gaps in health financing are required.

Urgent attention must be given to:

- An assessment of Jamaica's health financing needs
- The best financial and policy tools for meeting these financial needs
- Pooling of existing resources to mitigate individual-level health risk and increase universal health coverage.
- Preventing a further increase in poverty as a result of ill-health and catastrophic out-of-pocket payments

- Improvements in efficiency and effectiveness of resource use across the health system
- Cost effective health programme.
- Providing resources to improve primary health care and effective coverage, especially for the most vulnerable and those in the lowest quintile.
- Robust and modern Health Information System, including digitization of medical records for sharing of information and reducing waste of duplication of services
- Bringing services close to the people (overcoming geographic and infrastructural barriers especially with adoption of technology and engaging with the private sector in order to augment health delivery points.

Towards a UHC Road Map

Starting within the current financial year the consultation will start with resuming the discourse for the National Health Insurance Plan Green Paper and health financing consultation across the country. Even while that progresses there are key documentary evidence to be completed namely the Health Public Expenditure Review and the Fiscal Space for Health reports which will give more context to the discussion.

Figure 13: Key Next Steps towards UHC

APPENDIX

Fetus/Pregnant mother	Infant & Child	ADOLESCENT	ADULTHOOD	Elderly
• Treatment Services ○ Acute and chronic disease management and referral as appropriate • Maternal Care ○ Antenatal, Intra-natal, ○ Post Natal ○ Home delivery ○ Domiciliary service • Immunization ○ Age appropriate immunization • Growth & Development ○ Growth Monitoring will be a part of antenatal care offered) • Sexual & Reproductive Health ○ Counseling & Education, ○ Family Planning ○ STI/HIV Management, Risk Assessment, PMTCT • Nutrition ○ Nutrition promotion, growth monitoring and counseling • Preventative Management -NCDS ○ Risk factor Screening, ○ Prevention and Management ○ NCD Screening	• Treatment Services ○ Acute and chronic disease management and referral as appropriate • Immunization ○ Age appropriate Immunization • Growth & Development ○ Age appropriate growth and development screening and management • Sexual & Reproductive Health ○ Counseling & Education as indicated • Nutrition ○ Nutrition and breastfeeding promotion, growth monitoring and counseling • Screening and Preventative Management Communicable and NCDS ○ Risk factor Screening, Prevention and Management ○ NCD Screening	• Treatment Services ○ Acute and chronic disease management and referral as appropriate • Maternal Care ○ Antenatal, ○ Intra-natal, ○ Post Natal • Immunization ○ Age appropriate immunization • Growth & Development ○ Age appropriate growth and development screening and management • Sexual & Reproductive Health ○ Counseling & Education, Family Planning , STI/HIV Management, Risk Assessment, Prevention of Sexual Abuse and Violence • Nutrition ○ Nutrition Assessment & Management ○ Healthy Eating to Prevent Overweight and Obesity • Screening and Preventative Management Communicable and NCDS ○ Risk factor Screening, Prevention and Management ○ NCD Screening	• Treatment Services ○ Acute and chronic disease management and referral as appropriate • Maternal Care ○ Family Planning, ○ Antenatal, ○ Intra-natal, ○ Post Natal ○ Pre-pregnancy counseling for select groups ○ Home deliveries • Immunization ○ Age appropriate immunization • Sexual & Reproductive Health ○ Family Planning, STI/HIV Management, Risk Assessment, Menopause and Andropause Management • Nutrition ○ Nutrition Assessment & Management • Screening and Preventative Management Communicable and NCDS ○ Risk factor Screening, Prevention and Management ○ NCD Screening ○ Screening for cancers • Oral Health ○ Screening ○ Preventive care (sealant application) ○ Education and promotion ○ Extractions and fillings • Ophthalmology ○ Screening for visual disabilities ○ Diabetic Retinopathy, cataract, Glaucoma • Audiometry	• Treatment Services ○ Acute and chronic disease management and referral as appropriate • Immunization ○ Age appropriate immunization • Growth & Development ○ Age appropriate growth and development screening and management • Sexual & Reproductive Health ○ STI/HIV Management, Risk Assessment, Menopause and Andropause Management • Nutrition ○ Nutrition Assessment & Management • Oral Health ○ Screening ○ Preventive care (sealant application) ○ Education and promotion ○ Extractions and fillings • Ophthalmology ○ Screening for visual disabilities ○ Diabetic Retinopathy, cataract, Glaucoma • Audiometry ○ Screening for hearing disabilities • Mental Health ○ Social risk assessment ○ Mental Health assessment to include : ○ Cognitive Impairment ○ Substance Abuse Disorder ○ Mood Disorders ○ Psychotic Disorders, ○ Suicide Prevention
• Oral health ○ For the pregnant mother • Ophthalmology ○ Screening for visual disabilities for the newborn as indicated • Audiometry ○ Screening for hearing disabilities for the newborn as indicated	• Palliative Care (as needed) • Rehabilitative Care (as needed) • Oral Health ○ Screening ○ Preventive care (sealant application) ○ Education and promotion ○ Extractions and fillings • Ophthalmology ○ Screening for visual disabilities • Audiometry ○ Screening for hearing disabilities			
• Mental Health ○ Social risk assessment	• Mental Health ○ Social risk assessment ○ Mental Health assessment to include : ○ Developmental Disorders,	• Mental Health		

Fetus/Pregnant mother	Infant & Child	ADOLESCENT	ADULTHOOD	Elderly
○ Screening & education of mother for Substance Abuse ○ Depression screening • Health Promotion Community and Environmental Health ○ Home assessments ○ Health education and promotion for diseases or events of public health interest	○ Cognitive Impairment ○ Substance Abuse ○ Disorder ○ Mood Disorders ○ Psychotic Disorders, ○ Suicide Prevention • Health Promotion Community and Environmental Health ○ School health ○ Health education and promotion for diseases or events of public health interest • Acute diarrheal disease treatment and care • Anti-parasite treatment	○ Social risk assessment ○ Mental Health assessment to include : ○ Developmental Disorders, ○ Cognitive Impairment ○ Prevention of Alcohol ○ Tobacco and Substance Abuse Disorder ○ Mood Disorders ○ Psychotic Disorders, ○ Personality Disorders ○ Suicide Prevention • Palliative Care (as needed) • Rehabilitative Care (as needed) • Health Promotion Community and Environmental Health ○ School health ○ Health education and promotion for diseases or events of public health interest • Prevention of alcohol, tobacco and other drug use • Detection and treatment of tuberculosis • Asthma detection and treatment Prevention and treatment of malaria	○ Screening for hearing disabilities • Mental Health ○ Social risk assessment ○ Mental Health assessment to include : ○ Cognitive Impairment ○ Substance Abuse Disorder ○ Mood Disorders ○ Psychotic Disorders, ○ Suicide Prevention ○ Personality Disorders • Palliative Care (as needed) • Rehabilitative Care (as needed) • Health Promotion Community and Environmental Health ○ Workers health ○ Occupational Health ○ Health education and promotion for diseases or events of public health interest • Asthma detection and treatment • Anti-parasite treatment • Diagnosis and medical treatment of ischemic heart disease • Prevention of alcohol, tobacco and other drug use • Physical (Preventive Health Maintenance) Examination	○ Nuero-psychiatric Disorders • Palliative Care (as needed) • Rehabilitative Care (as needed) • Health Promotion Community and Environmental Health ○ Home assessment NCD Education ○ Health education and promotion for diseases or events of public health interest • NCD Education • Prevention of alcohol, tobacco and other drug use • Disease education circulatory system, prevention and healthy eating • Education, detection and treatment of low back pain, neck pain and migraine • Detection and Treatment VIH+ • Detection and treatment of tuberculosis • Prevention and treatment of epidemics • Asthma detection and treatment • Diagnosis and medical treatment of ischemic heart disease • Anti-parasite treatment

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