

MINISTRY OF HEALTH

**DISCUSSION PAPER
ON HEALTH FINANCING
REFORM
IN BARBADOS**

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OVERVIEW

This paper forms the basis for public discussion on the adoption of alternative health financing mechanisms for Barbados. It is aimed at providing substantial information on approaches to health financing that ensure universal health coverage while taking into account Barbados' specific social and economic environment.

The need for discussion in this area has become paramount at a time of austerity in the Barbadian economy and, rising health care costs, attributed to an increasing percentage of elderly persons in the population, an increasing prevalence of non-communicable diseases, and the threat of emerging and re-emerging communicable diseases. Additionally, there is a growing demand by consumers for greater choice and access to healthcare technologies and services. As more innovative practices and new treatments are introduced in industrialised countries, managers in the health care system must strike a balance between satisfying the increasing desires of their clients for access to these new technologies and managing costs.

With the emergence of the global economic crisis, the Director General of the World Health Organization (WHO), Dr. Margaret Chan in 2010 advised Member States to examine their budgets to determine opportunities to improve efficiency and make better use of resources, rather than solely seeking new sources of financing their health services. The strategies she proposed included streamlining procurement practices, utilizing generic products, and improving financing and administrative procedures.

This paper examines the health situation in Barbados and outlines the demands and challenges facing the health care system. It also provides a synopsis of the global health financing principles and the challenges and obstacles confronting countries employing different health financing models.

An analysis of the current health expenditure of Barbados provides the framework for understanding the sources and uses of funds, which is a critical element to inform future health financing policies and plans. The fiscal space options available for additional funding of Barbados health services are outlined. The paper concludes with the way forward, providing recommendations on the necessary processes for implementing health financing reform in Barbados.

HEALTH FINANCING: PRINCIPLES AND OBJECTIVES

The term “health financing” refers to the function of a healthcare system that is concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively (WHO, 2010). Health financing is one of the six functions of a health system and is necessary for the achievement of national health policy goals.

In 2005, WHO Member States endorsed a resolution urging governments to develop health financing systems aimed at attaining and maintaining “universal coverage/universal health coverage” - described as raising sufficient funds for health in a way that allows people in the society to access needed services without experiencing financial catastrophe. The resolution also recommended that Member States must ensure that coverage is equitable and that the appropriate tools required to monitor and evaluate progress are established.

Globally, many countries have a great deal to accomplish in order to achieve universal health coverage. According to the WHO (2010a), both industrialised and developing countries have not been able to ensure that everyone has

immediate access to every technology and intervention that may improve their health or prolong their lives.

Generally, funds to finance health services are generated from the following sources: taxes (income, value added, sales or excise); insurance premiums contributed by both employers and employees; and out-of-pocket payments by households at the time health care is procured. In some countries, funds from these sources are utilised in various combinations to meet the health financing requirements of the system. In this regard, the following critical policy issues in respect of the financing of the healthcare system are asked:

- Who should bear the burden of paying?
- What percentage of income should each person contribute to the operations of the healthcare system?
- What quantity of funds should be collected annually, and by what mechanism should these funds be pooled, and allocated, to adequately meet the health care needs of the population?
- Would the existing financing arrangement be adequate to sustain universal health coverage in the medium to long term?

One of the substantial barriers to attaining universal health coverage is the reliance on direct (out-of-pocket) payments at the time care is required. Prescription drugs, doctor's consultation fees, hospital visits as well as laboratory and other diagnostic investigations may account for these payments. Furthermore, although individuals may be enrolled in some type of health/medical insurance plan, these often require the beneficiary to contribute in the form of co-payments, co-insurance or deductibles. Generally, Health Plans utilize co-payments, co-insurance and deductibles to dampen demand for services and ultimately reduce costs.

The obligation to pay directly for services at the time of need may prevent many individuals from accessing health care when they need it most. For those who

do seek treatment, it can result in severe financial hardship, even impoverishment (WHO, 2010a). According to WHO (2010a), the incidence of financial catastrophe and impoverishment is highest in countries where aggregate out-of-pocket payments represent more than 15 to 20 per cent of total health expenditures.

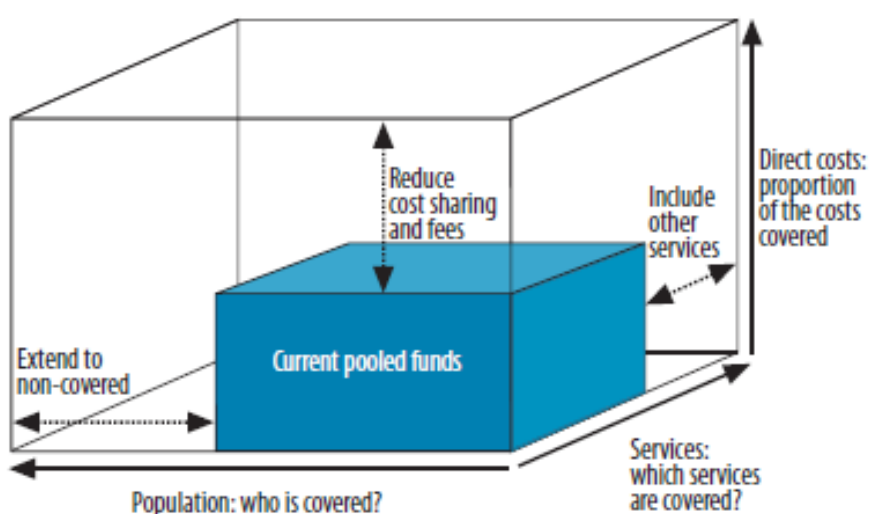
Researchers suggest that the only way to reduce reliance on direct payments is for governments to encourage the risk-pooling prepayment approach, which is the path chosen by most of the countries that have come closest to universal health coverage. This approach is based on payments made in advance of an illness, pooled in some way and used to fund health services for an entire population. Hence, access to care is not determined by one's contribution to pooled funds and the poor are guaranteed access.

Additionally, WHO (2010a) has advocated for contributions to be compulsory, otherwise the rich and the young and the healthy would opt out of the financing system. The principle in insurance schemes is for the rich and the healthy to subsidise the poor and the sick; the young subsidise the old, and workers subsidise those who are unemployed. Compulsory contribution schemes are set up to guarantee that there will be sufficient funds to cover the needs of the poor and sick, however, it has been noted that pools that protect the health needs of a small number of people tend not to be viable in the long term as a few occurrences of expensive illness can wipe them out.

Therefore, governments must establish the appropriate legislative and administrative mechanisms to manage pooled resources and organise the purchase of services and remuneration methods. While these functions may be performed by either the public or private sector, they must be regulated by the government.

Figure 1 illustrates the three dimensions that countries should consider when seeking to achieve universal coverage – population coverage, the range of services to be provided and the proportion of the total costs to be met. The smaller cube labelled ‘current pooled funds’ depicts the situation in a country where about half the population is covered for about half the possible services, but where less than half the cost of these services is met from pooled funds. To get closer to universal coverage, the country would need to extend coverage to more people, offer more services, and/or pay a greater part of the cost.

Figure 1 – Three dimensions to consider when moving towards universal coverage



Source: World Health Report (2010a)

From Figure 1, it is noted that another critical issue is determining the amount and mix of healthcare services that should be accessible to the population. Health finance theory suggests that a country’s population has the right to access a set of prevention, promotion, treatment and rehabilitation services that will contribute to each individual attaining the highest possible level of health.

In this regard, one of the concerns is the role of primary health care in the organization of the healthcare system.

A strong and effectively functioning primary health care system is the underpinning of universal health coverage. Since no country in the world has sufficient resources to treat its way out of illness, the appropriate strategy that is universally adopted is that of primary prevention, the promotion and maintenance of health. It is also a failure of the system when hospitals demand and are allocated a larger share of the budget for curative care instead of strengthening the primary health care delivery system.

A dimension in the path to universal health coverage relates to the overall issue of resource allocation and the optimization of utilization to ensure efficiency and effectiveness. The 2010 World Health Report estimated that between 20 and 40 percent of resources allocated to health services are wasted. Promoting efficiency would greatly improve the ability of health systems to provide quality services and improve health care outcomes for the population. Therefore, the Report suggested that countries should explore opportunities to achieve more with the same resources. In this regard, areas of wastage identified included:

- Overuse of investigations and procedures
- Over supply of equipment
- Inappropriate or costly staff mix
- Unmotivated health workforce
- Inappropriate hospital admissions and excessive lengths of stay
- Inappropriate hospital size
- Medical errors and suboptimal quality of care
- Corrupt procurement practices and wastage
- Inefficient mix of interventions

It is vital that each country assesses the nature and causes of inefficiencies and determine the costs and likely impact of the possible solutions. While this task can be demanding and time consuming, the potential health gains from reinvesting these resources in better ways to improve population health are enormous (WHO, 2010a).

In summary, the path to universal coverage infers the simultaneous application of the following three priorities: a country must raise sufficient funds to finance the health services offered to its population; there must be a reduction of reliance on direct payments by households to finance services; and there must be improvement in efficiency at all levels of its healthcare system. Although raising sufficient funds to service the health care system is crucial, the efficient and equitable use of resources is an important factor that must be considered in the context of universal health coverage.

THE APPROACH TO UNIVERSAL HEALTH COVERAGE IN BARBADOS

The Health Services Act 1969 CAP 44 of the Laws of Barbados provides the policy framework for the ‘promotion and preservation of the health of Barbadians. Specifically, the Act has provided the authority for the prevention, treatment, and surveillance of disease as well as the establishment of health services institutions. It also allows for the administration of the health services through funds voted by Parliament.

Successive Development Plans since independence in 1966, and the Barbados Strategic Plan for Health articulate the philosophical basis of the health services,

through which the State has responsibility for the provision of a comprehensive health service, funded by general taxation and available to citizens and approved permanent residents free at the point of service delivery. Since independence, the demographic and epidemiological profiles of Barbados have changed, impacting on the overall demand for health. Concurrently, the supply side of the health services too has changed, giving rise to a vibrant private for-profit sector which has grown alongside the public sector.

The centerpieces of Barbados' healthcare system have been the primary health care delivery framework established on the principles of the Declaration of Alma Ata, and a secondary and tertiary care system established in collaboration with the Faculty of Medical Sciences of the University of the West Indies. This healthcare system is supported by a health financing model based on tax revenues that pay for the delivery of services to the population. This approach to health care delivery and financing has effectively contributed to Barbados' position as one of the countries within the Americas with a very high level of human development.

At the end of the last decade, average life expectancy was 75.8 years (72.7 years for males and 78.6 years for females)¹. Non-communicable diseases, which include heart disease, stroke, diabetes mellitus, chronic pulmonary disease and some cancers, account for the leading causes of death and morbidity in Barbados. Concomitantly, communicable diseases have diminished as the leading causes of illness and death.

Indicators of child and maternal health strongly indicate that mothers in Barbados have successful pregnancies, and their children have a very high chance of reaching adulthood in good health. In 2012, the infant mortality rate was 10.7 per 1000 live births, the under-five mortality rate was 11.6 per 1000 live births, and there were two maternal deaths. Barbados has been successful in meeting regional and international targets related to the occurrence of vaccine

¹ Abridged Life Tables for Barbados 1999 – 2001, Barbados Statistical Service

preventable diseases and in 2013, the Ministry of Health was awarded the Caribbean Public Health Agency shield for excellent surveillance for immunization diseases under the Expanded Programme on Immunization (EPI).

Barbados continues to maintain an incidence rate of zero cases of polio, neonatal tetanus, measles, rubella, yellow fever and congenital rubella syndrome. Over the past two decades immunization coverage has been consistently high, between 90-93%. New vaccines added to the EPI schedule include Hepatitis B, Haemophilus Influenza, Pneumococcal, Varicella, and in January 2014, Human Papilloma Virus (HPV) vaccine to girls eleven years and over.

Barbados' HIV/AIDS programme is regarded as a model in the Caribbean region and beyond. The success has been augmented by the universal availability of antiretroviral treatment for individuals living with HIV, resulting in a significant reduction in mortality and improved quality of life for affected individuals and their families. Added to this is the reduction in mother-to-child transmission, with no reported cases since 2007. This success has been achieved in conjunction with international and regional cooperation.

Transmissions continue to trend downwards with 138 new HIV cases recorded in 2012. At the end of 2012 there were 2,024 people living with HIV, and the HIV prevalence in 15-49 year olds for 2012 was estimated at 1.2%. There has been a reduction of AIDS mortality rates from 50% to less than 10% and Barbados has achieved universal access to treatment. All donated blood is screened for HIV as part of the Blood Safety Programme at the Queen Elizabeth Hospital.

Population specific health education programmes, affordable medicines, improved health technologies and surveillance systems have brought Barbados closer to achieving several of the health-related Millennium Development Goals.

The foregoing indicators have been made possible as a result of barrier-free access to a wide range of preventive, curative, and rehabilitative services in the

public sector. Maternal and child care services, family planning clinics, immunization, oral health services for children up to age sixteen, general practice clinics, nutrition counseling, access to essential drugs and environmental health services constitute the core health care services at the primary care level.

Attendances at the polyclinics and the Queen Elizabeth Hospital give an indication of overall utilization of the services they provide. Overall attendances at the polyclinics increased by 10.8% from 445,953 in 2010, to 494,080 in 2012. Attendances for Maternal and Child Health Services were 14.1% of total polyclinic attendances in 2010 but had declined to 12.0% in 2012. On the other hand, 36% of polyclinic attendances were for GP consultations.

Inpatient services available at the secondary and tertiary care level include medicine, surgery, paediatrics, obstetrics and gynaecology, with sub-specialties of cardiovascular surgery, neurosurgery and orthopedics. In 2012, there were 20,597 admissions to the QEH, and over 96,550 outpatient clinic attendances were made for services including ophthalmology, general medicine and surgery, obstetrics and gynaecology, and otolaryngology (ENT).

Barbados' ageing population and the rising prevalence of non-communicable diseases have created additional demands on the Ministry of Health for the provision of preventative, curative and rehabilitative services. One of the Ministry's approaches to meeting the demand for new services has been to strategically purchase necessary services from appropriately skilled private providers, particularly where these services have been proven to be cost effective. Currently, the Ministry purchases cardiovascular rehabilitation services, dialysis treatment, specialised diabetes services, and drug rehabilitation services.

Additionally, the QEH may refer some patients to hospitals in either North or South America, depending on the nature of the case, for medical care not available in Barbados. Access to overseas medical services is made possible through the Medical Aid Scheme, at a cost of \$4.0 million annually. The range

and number of cases sent overseas for treatment have diminished due to the introduction and establishment of a variety of medical specialties here in Barbados during the past two decades.

Access to essential medicines is secured by way of the Barbados National Drug Formulary which is administered by the Barbados Drug Service. Children under the age of sixteen, persons over the age of sixty-five, and individuals who have been diagnosed with diabetes, cancer, hypertension, glaucoma, asthma and/or epilepsy can obtain formulary drugs free of charge through the facility of the Special Benefit Service. Prescriptions can be filled at either government pharmacies or private participating pharmacies and there is no provision for patients to make a co-payment. However, patients who opt to fill prescriptions under the Special Benefit Service at private participating pharmacies are required to pay the dispensing fee only. On average, 2,700,000 prescriptions are filled by the Barbados Drug Service annually.

The Government of Barbados finances the foregoing range of health services and other government activities from revenues generated from taxes and approved by Parliament for the purpose. Given the absence of earmarked taxes or special funds allocated to finance the public healthcare system, the Ministry of Health is required to compete for a share of public finances and that share is subject to fluctuations based on the Government's revenue intake. During periods of economic downturn, there is a risk to the sustainability of health care programmes.

Over the past decade, the *Barbados Strategic Plan for Health 2002 to 2012* focused attention on issues in health systems strengthening, including continuous quality improvement, human resources for health, health information systems, containment of costs, accountability and governance and the financing of health services. Technical assistance as well as financial support for several health reform initiatives was secured from organizations such as the World Bank, the Centers for Disease Control and Prevention, the Pan

American Health Organization/World Health Organization, the European Union and the United States Agency for International Development.

The Institutional Assessment and Expenditure Review of the Health Sector, a study commissioned in 2012 by the Government of Barbados and the Inter-American Development Bank has unraveled some of the complexity of the issues in health systems strengthening. This Study showed that the performance of the Ministry and the QEH continued to be constrained by, *inter alia*, inadequate health information systems, insufficient funding, absence of cost accounting systems, poor quality improvement schemes and inadequate income generation in the health sector. The study also suggested that overall efficiency of the sector could be improved if clinical services at the QEH and the polyclinics were redesigned, the approach to the management of patients with NCDs was systematic, and if procurement processes were reformed.

The Study suggested that the efficiency gains from the foregoing measures would reduce the cost of the health services substantially, and recommended that in the short term, the Ministry should undertake a number of reviews to design and implement the efficiency measures. In the meantime, the Ministry has undertaken a health expenditure tracking exercise intended to analyse the flow and uses of funds in the entire health sector. The findings of this exercise are discussed in the following section.

BARBADOS' HEALTH EXPENDITURE

Health expenditure data is essential for tracking and improving resource allocation, informing health policies, and planning for future health programmes and health financing initiatives. Health expenditure exercises namely National Health Accounts and Health Satellite Accounts provide a range of indicators on

the basis of expenditure information collected within an internationally recognised framework.

In 2012, with the support of the Pan American Health Organization (PAHO), the Ministry of Health conducted a health expenditure exercise using the Health Satellite Accounts (HSA) methodology to analyse the sources and uses of funds on health products, services and medical care activities. This methodology, which uses the System of National Accounts (SNA) as its central reference, is the national income accounting system used by the Government of Barbados. However, the Ministry of Health was unable to use this methodology to its full capacity to estimate private health expenditure as the Supply and Use Table is incomplete.

Consequently, in June 2014, the Ministry of Health in collaboration with the United States Agency for International Development (USAID) Health Finance and Governance Project and the University of the West Indies Health Economics Unit initiated a National Health Accounts Study. Health Accounts is an internationally standardized tool used in over 130 countries to summarize, describe, and analyse the financing of health systems by capturing data on spending by the public sector, private sector including households, nongovernmental organizations and donors. Health Accounts are based on the System of Health Accounts (SHA) framework, which was developed and revised by key international stakeholders over the past two decades. The latest version of SHA, known as “SHA 2011” was developed by the Organization for Economic Co-operation and Development (OECD), EUROSTAT, and the World Health Organization (WHO). The 2012-13 Health Accounts Study in Barbados was conducted using the SHA 2011 methodology (see Appendix 1).

In this analysis, the term ‘health expenditure’ conforms to the WHO definition, which is the expenditure whose primary purpose is to restore health, improve and maintain health for the nation and individuals during the time under consideration (WHO, 2013). Water, sewerage, sanitation and refuse collection,

and environmental health services are kept outside the boundary of health accounts. The Study sought to answer the following health financing policy questions:

- 1) Who are the main contributors to health spending and how much does each contribute?
- 2) To what extent are funds pooled in order to minimise the risk of catastrophic expenditure?
- 3) How does spending compare at the different levels of the healthcare system?
- 4) How is health spending allocated to prevention, treatment and other activities?
- 5) What is the spending across disease conditions?

In respect of the first question, the Study found that Total Health Expenditure (THE) in Barbados in 2012-13 was \$732,703,759, of which 98% represented recurring spending i.e. spending on health goods and services that were consumed within the year of the Health Accounts analysis. The remainder of spending was for capital investment (spending on goods and services whose benefits are consumed over more than one year) and care related items such as social care for HIV (see Appendix II). This THE represented 8.7% of Barbados' gross domestic product. Also, this expenditure was equivalent to \$2,582 per capita. Compared to the rest of the Caribbean, Barbados' per capita health expenditure ranked the third highest in the Caribbean behind the British Virgin Islands and the Bahamas.

The main source of health spending (55%) was funds voted by Parliament and allocated to the Ministry of Health. Government health expenditure as a percentage of the total Government budget was 11.1%. Households represented the second biggest contributor to THE, of which 39% (\$285,754,466) was paid

through out-of-pocket spending. Private health insurance plans contributed 5% of THE (\$36,635,188). It was estimated that 27% of the population was covered by health insurance plans of which 13% were employer-based plans and 14% individual-based health plans. The fact that out-of-pocket expenditure by households constitute such a substantial proportion of THE is a reason for concern, since according to the WHO 2010 Report, at least one percent of households may be at risk of falling below the poverty line.

The Study also found that approximately one third of THE is spent at the primary care level, primarily through polyclinics and private doctors' offices. Approximately 44% of health spending was for secondary care, 6% for tertiary care, 3% for long term care and 9% for the purchase of drugs, laboratory tests and radiological investigations in the private sector. Due to limitations in the data, only 47% of the expenditure was attributed to specific diseases.

Out-of-pocket spending of approximately \$285.8 M is an interesting finding. Approximately 68% of this expenditure was for ambulatory care at private doctor's offices and private hospitals, while only 10% was spent on inpatient care. It is important to note that 6% of household out-of-pocket expenditure was spent at the private wing of the QEH. These findings appear to suggest that households may perceive the quality of ambulatory care in the private sector is higher than in the public sector. Also the 10% expenditure on inpatient care appears to suggest that paying patients may opt for public inpatient care since this is an option available to them at the QEH. These findings warrant further study. A negligible proportion of household out-of-pocket spending was on overseas care, which may be due to the availability of specialist services in Barbados.

Spending fifty percent of THE on secondary and tertiary care has serious policy implication for the Health Services in Barbados. It adds credence to the position that the Ministry of Health should strengthen the promotion of health, and renew

the primary health care strategy. While this suggests the need for additional research into cost-efficiency and resource allocation decisions, primarily as they relate to improving quality generally, there are a number of initiatives that could be implemented with minimal investment cost in the short term. These include reducing the percentage of patients with NCDs who go on to develop serious complications that can only be treated using costly therapies; and expanding community based services for the elderly, persons with mental illnesses and persons with palliative care needs. Often, the absence of early intervention leads to many of the foregoing cases incurring long hospital stays and consuming costly drug and other therapies.

The policy implications of the foregoing findings can be summarised in the following questions:

- Are Barbadians spending too much on health?
- To what extent should the spending on secondary care and pharmaceuticals be reorganised and shifted towards prevention?
- What is the incidence of out-of-pocket spending and to what extent will the poor be impoverished by this spending?
- What is the quality of care being offered and accessed in both the public and private sectors?

Compared to the rest of the Caribbean, Barbados' health expenditure per capita (US\$ 1,291) is surpassed only by The Bahamas with US \$1,647 and the BVI with US \$2,200. On the face of it, there would seem to be a case for a greater focus on cost containment and to improve the cost-effectiveness of the existing services. This is consistent with the recommendation of the 2012 Institutional Assessment and Expenditure Review of the Health Sector.

Out-of-pocket spending at 39.4% of THE is much higher than the WHO benchmark of 20% and higher than the regional average of 30%. There is therefore a need for further research to determine the incidence of this spending

and whether the health outcomes warrant the expenditure. Furthermore, if the evidence show that the bulk of this spending is being incurred by the lower income groups then a policy response in favour of greater pooling will be required.

In summary, Barbados like other countries face pressure to find additional financing for health services in light of escalating costs occasioned by the NCD epidemic and an ageing population. The threat of new and re-emerging infectious illnesses, and increases in the prevalence of mental health challenges suggest the cost will continue to spiral. While there is a funding gap in the public sector, due primarily to the Government's cash flow situation, the evidence is that overall expenditure in the health sector is 8.9% of Barbados' GDP. In other words, this level of health expenditure approximates that of industrialised countries aiming for universal health coverage.

Many industrialised countries have reformed their healthcare system along the model of social-health insurance schemes, introducing in the process, mechanisms and incentives for healthcare providers to minimize costs and for the population to pursue health-seeking behaviour. Tax-based health financing models have not demonstrated sufficiently the capacity do this. The following section discusses briefly the experiences of other countries in health financing reform.

EXPERIENCE OF OTHER COUNTRIES IN FINANCING NATIONAL HEALTH CARE SYSTEMS

Globally, only a few countries have developed health financing systems that may be considered as coming close to achieving the goal of universal health coverage. Those countries that come close to achieving universal health coverage have been successful in using a combination of financing sources, without reliance on direct out-of-pocket payments to meet the health care needs of their population. The basic principle in the various financing models is the pooling of funds, either via taxes, or insurance contributions, as is found in the U.K., or in the USA and Canada respectively.

The UK is about one of the only countries in the world to retain a health financing system based almost exclusively on taxation. Referred to as the Beveridge model, taxes are approved by Parliament and allocated to the British National Health Service, which also provides health care services to the population.

The US system has been based on managed care (private insurance) plans such as Health Maintenance Organisations (HMOs) and Preferred Provider Organisations (PPOs). Since these health plans exclude unemployed and underemployed populations, the US Government has facilitated access to health for the elderly through Medicare. Given the significant gaps in access to health for a proportion of the population, the US President in 2010 introduced the health reform initiative popularly known as 'Obama Care' to redress the situation.

The Canadian system is funded by a mix of public finances, private insurance and out-of-pocket payments. Unlike the UK in which the government is a

provider (owns hospitals and pays the salaries of physicians), in Canada, physicians operate as independent practitioners and are contracted to provide medical services to the population

In many of the newer Member States of Central and Eastern Europe, a major change since the early 1990s has been the shift from tax to social insurance as the dominant contribution mechanism. However, in many of these countries the economic and fiscal context is particularly unsuited to employment-based insurance due to high levels of informal economic activity and unemployment. Consequently, governments have usually continued to rely on tax allocations to generate sufficient revenue. In some cases, this has been seen as a failure of the social insurance “system” (Foubister, Mossialos & Thomson, 2009).

The European Union’s health system provides broadly comprehensive benefits, usually covering preventive and public health services, primary care, ambulatory and inpatient specialist care, prescription pharmaceuticals, mental health care, dental care, rehabilitation, home care and nursing home care.

According to the Report of the Caribbean Commission on Health and Development [CCHD], 2006, two key contextual factors in the Caribbean influence the type of health financing systems – firstly, budgetary allocations for health services and secondly, the level of household spending and the growth of the private sector. Allocations from the central budget are the most dominant source of health financing, however several countries within the region have established national health insurance (NHI) systems as shown in Table 2. According to Lalta (2013), in eight countries within the region with social health insurance/national health insurance systems, approximately 1.0-9.0% of insurable wage is deducted from employees’ payroll. The CCHD Report indicates that in some of these countries there are ongoing problems in monitoring, evaluating and tackling design and operational deficiencies.

Table 2- Typology of Health Financing Systems in the Caribbean

Tax/Budget Financing (60+%)	Social Health Insurance (SHI) (60+%)	Hybrid (Taxes, SHI and Private Health Insurance)
Anguilla	Aruba	Antigua
Barbados	Bermuda	Bahamas
Belize	Cayman Island	British Virgin Islands
Dominica	Curacao	Jamaica
Grenada	St. Maarten	Trinidad and Tobago
Montserrat	Suriname	
St. Kitts	Turks and Caicos Islands	
St. Lucia		
St. Vincent		

Note: In all countries, fairly high levels of out of pocket payments (means – 33%)

Source: Lalta (2013)

Key Observations from Country Experiences

1. Creating a single national pool of funds earmarked for health can facilitate strategic direction and coordination throughout the health system.
2. Health systems predominantly financed through employment-based social insurance contributions may benefit from broadening the revenue base to include income not related to earnings. A large informal sector or a high unemployment rate could compromise the sustainability of the system.
3. Encourage administrative efficiency by minimizing duplication of functions and tasks.
4. Encourage strategic resource allocation to ensure that health resources match health priorities and needs.

5. Limit reliance on private finance (private health insurance, user fees) and ensure that there are clear boundaries between public and private finance so that private finance does not draw on public resources or distort public resource allocation and priorities.
6. Effective monitoring of claims for medical treatment locally and overseas is required.
7. A well developed and functioning national health information system is necessary to make informed decisions.

OPTIONS FOR STRENGTHENING BARBADOS' HEALTH FINANCING SYSTEM

The findings presented in this Paper demonstrate the following weaknesses in Barbados' tax-based health financing model:

1. Reliance on tax revenues to finance public health services poses a risk for sustaining the delivery of effective and quality healthcare services. It stands to reason that any decline in the revenue intake by the government would be reflected in a reduced allocation to the health sector and this assertion is supported by evidence. In light of the fact that the demand for health services is constantly rising, and healthcare costs are not static, reductions in the budgetary allocations to the primary health care services

and the Queen Elizabeth Hospital result in reductions in healthcare outputs, demonstrated by increased morbidity, long waiting times for access to specialized services, and/or rationing of services.

2. The intersecting of privately financed health services and the public health service tend to result in situations where public resources are used to subsidise private care. This situation distorts public resource allocation and priorities.
3. Inadequate incentives to control healthcare costs: in the public sector, physicians are salaried; in the private sector, they are paid on a fee-for-service basis. A payment scheme for primary care physicians based on capitation in some industrialised countries has tended to incentivize physicians to adequately manage their patient case load.
4. The budgetary allocation for acute, secondary and tertiary care services is not related to the case mix. The evidence shows that hospitals in which case-based payment systems, such as Diagnostic Related Groups (DRGs) are implemented, are far more efficiently operated.

The foregoing suggests that there are structural weaknesses inherent in Barbados' health financing system. Consequently, options for strengthening the health financing system cannot simply be about raising more taxes to finance health services, or introducing co-payments or user fees. Rather, the substantive issues are:

- guaranteeing the certainty of funding through a mechanism that earmarks the funds for healthcare;
- pooling funds to protect the poor and the sick under a system of social (compulsory) health insurance;
- improving efficiency, that is getting more output from the resources allocated; and
- introducing appropriate incentive schemes for paying physicians and hospitals.

The Ministry is proposing in the short term to undertake the following measures:

- i. Conduct an actuarial assessment of Barbados' long-term healthcare financing needs. The Terms of Reference for this assessment will require proposals for either strengthening the current system of pooled financing, or changing to a social insurance model. In either case, recommendations should be made to reform of the system of remunerating physicians, paying hospitals and healthcare providers generally;
- ii. Strengthen the primary and secondary health care systems by eliminating inefficiencies through the redesign of clinical services at the QEH, the polyclinics and other institutions;
- iii. Eliminate inefficiencies in the support services, including laundry, dietary and housekeeping services at the government institutions, and in the procurement function across the Ministry;
- iv. Conduct a willingness-to pay study among Barbadians to determine the full extent to which the population would wish to contribute further to health care costs.
- v. Engage public and private stakeholders in the health sector on the issue of health financing options as well as conduct a series of town hall meetings on the proposed health financing reform initiative.

In the interim, however, the Ministry would still be faced with the problem of inadequate funds to meet the daily healthcare demands of the population. Two possible options to address the financing deficiency in the short term are:

1. Implement higher taxes on alcohol, tobacco, sweet drinks and other foods that drive the NCD epidemic, and earmark these funds for the health system.
2. Reintroduce a health levy on income and earmark the funds to supplement the financing of the health system. For example, a one percent levy on

income (based on figures for the 2013 Income Year) is estimated to yield \$24,679,410 (see Appendix 2 for calculation).

Given the weak economic situation in the country, the imposition of any additional taxes would have to be carefully considered.

SUMMARY

While there is no ideal health financing model, and no single country has the ideal healthcare system, there are a number of fundamental principles on which a good system is based. The theory on healthcare financing and the evidence from both industrialized and developing countries aiming to achieve universal health coverage suggest that the financing model must be based substantially on a system of pooled funds. The social health insurance model according to the literature on best practices, appears to promise higher equity, and better cost containment strategies than the tax based model of financing.

These basic models of health financing indicate that there are cost implications for citizens. Someone has to pay. It is clear that an expenditure of 8% of GDP on health care is high for the region, yet there are gaps currently in Barbados' delivery system. Furthermore, 39% of Total Health Expenditure contributed out-of-pocket by households suggest there is a need for the Ministry of Health to ensure better pooling of these resources, and in the process offer better protection to the population.

The proposals outlined in this Paper recommend urgent attention to the redesign of clinical and support services in order to improve efficiency across the system. Additionally, conducting an actuarial study of Barbados' long-term health financing needs, with recommendations for re-aligning the system along the lines

of a social health insurance model will be a fundamental policy shift. Therefore, all stakeholders should be apprised and take the opportunity to contribute meaningfully to public discussions on health financing reform in Barbados.

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