Managing and Financing Health To Reduce the Impact of Poverty In the Caribbean

Implementing Decentralization and Financing Strategies while Protecting the Poor

Policy Document

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Pan American Health Organization
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Caribbean Community CARICOM
Table of Contents

EXECUTIVE SUMMARY ........................................................................................................................................... 3

CONTRIBUTORS ......................................................................................................................................................... 6

INTRODUCTION .......................................................................................................................................................... 7

BACKGROUND ............................................................................................................................................................ 8

WHY DECENTRALIZATION AND HEALTH CARE FINANCING? .................................................................................. 8
WHO ARE THE POOR AND WHY FOCUS ON THEM? ................................................................................................... 8

DECENTRALIZATION ..................................................................................................................................................... 9

WHAT IS THE CONTEXT AND FORM OF DECENTRALIZATION BEING UNDERTAKEN IN DIFFERENT COUNTRIES? ..... 9
TYPES OF DECENTRALIZED SYSTEMS .......................................................................................................................... 10
RISKS AND POSSIBLE SOLUTIONS ............................................................................................................................... 13
HOW CAN DECENTRALIZATION PROTECT THE POOR? .................................................................................................. 15
DECENTRALIZATION, PRIVATIZATION, AND PROTECTING THE POOR ....................................................................... 16

HEALTH CARE FINANCING ......................................................................................................................................... 16

IS THERE A FUNDING GAP? ....................................................................................................................................... 18
WHAT ARE THE MECHANISMS OF HCF? ........................................................................................................................ 19

TRADITIONAL FINANCING MECHANISMS ....................................................................................................................... 19
Public financing ............................................................................................................................................................ 19
User Fees ....................................................................................................................................................................... 19
Private Health Insurance ............................................................................................................................................. 20
National Health Insurance ........................................................................................................................................... 22

COMPLEMENTARY FINANCING MECHANISMS ............................................................................................................... 23
Subsidies ....................................................................................................................................................................... 23
Subsidies to the poor ...................................................................................................................................................... 24
Subsidies to other vulnerable groups ............................................................................................................................. 25

ADDITIONAL ISSUES FOR CONSIDERATION ................................................................................................................. 25
PROVISION OF PRIVATE SERVICES IN PUBLIC FACILITIES .................................................................................. 27
CONTRACTING SERVICES TO THE PRIVATE SECTOR ................................................................................................. 27

THE OVERLAP BETWEEN DECENTRALIZATION AND FINANCING ............................................................................. 28

DEVOLUTION/FINANCING OPTION .................................................................................................................................. 29
DELEGATION/FINANCIAL OPTION .................................................................................................................................. 29
DECONCENTRATION/FINANCIAL OPTION ......................................................................................................................... 30

HOW TO ENSURE THAT THE LINK WORKS EFFECTIVELY? .......................................................................................... 30

Tables
1. Types of Decentralization. Positive and Negative Aspects .......................................................................................... 12
2. Scheme for Analysis of Risks and Policy Options ........................................................................................................ 14
3. Financing Mechanisms: Advantages and Disadvantages ............................................................................................. 26

ANNEXES
1. Problems of Health Sector Reform and Reform Objectives ........................................................................................ 31
2. Basic Indicators of Attainment and Potential ................................................................................................................ 32
3. Poverty Alleviation Programs ........................................................................................................................................ 33
4. Access, Illness, and Utilization Patterns between the Poor and Non-Poor in the Caribbean ........................................ 34
5. Basic Figures on Health Care Financing and Economic Activity .................................................................................. 35
6. National Health Insurance and the Health of the Poor .................................................................................................. 36
Executive Summary

Decentralization and health care financing are two of the main health reform strategies being pursued by Caribbean Countries. Poverty reduction programs are also being advocated as an integral aspect of human development and economic growth in the entire region. This document examines how specific aspects of health reform can be implemented and at the same time protect the poor.

In the initial phase of the Project, the linkages between poverty and health were analyzed by the Health Economics Unit, University of the West Indies. It was based on data from the survey of living conditions (SLC) for Jamaica; the living standard measurement surveys (LSMS) for Guyana and Trinidad and Tobago, and country poverty assessments (CPA) for Belize, St. Lucia, and St. Vincent. The study showed that the poor generally have less access to quality health care, they utilize health services less than the non-poor, and they are increasingly at a disadvantage in financing access to health services. This raised the question of how to implement the health sector reform strategies and avoid the unwanted and unfair effects on the poor.

Three internationally recognized models of decentralization—devolution, delegation and deconcentration—are being implemented across the Caribbean. Different countries have adapted different models. In some cases, such The Bahamas, Barbados and most of the OECS, countries have opted for a combination or hybrid of two of the three models. Each of these, in turn has demonstrated positive and negative effects, as well as risks. Drawing on the experience in the region and elsewhere, a series of policy recommendations have been provided. These include: (1) establish standardized national mechanisms for identifying the beneficiary populations; (2) involve the consumer in program planning; (3) compare the benefits of establishing new administrative activities to using existing facilities, when setting up regional health authorities; (4) Identify one or two key issues that link other sectors to health, and (5) prioritize those health activities that cannot be intersectorally linked.

A viable decentralization process is a prerequisite to the implementation of pro-poor policies. Such policies include: (1) placing emphasis on a needs-based financing strategy that targets government subsidy for public health care delivery to vulnerable groups; (2) increasing the use of preventive care services by the poor; (3) realigning spending from institutions to communities, and (4) achieving financial sustainability by using a needs-based formula for a set of services according to each country’s health plan.

Decentralization is being implemented at a time when the for-profit private sector is assuming a greater role in the delivery of health care. This sector is less likely than the NGO and the public sector to focus on the poor. The leadership role of the ministries of health is essential with respect to regulation, communication, and accountability. In addition, it must ensure that quality and equity are core values, whether or not the system has been financially or structurally decentralized or privatized.

Health financing is concerned with two interrelated issues: (1) where is the money for financing provision of health to come from; and, (2) what is the most efficient allocation of those
resources. There are three recognized sources of financial flows: financing/expenditure, funding/allocation of resources, and remuneration/compensation to health system workers. This policy document focuses on the importance of designing and implementing a health care financing policy based on a sound assessment of the respective financial mechanisms. They need to be undertaken within the framework of the macroeconomic and social policies of each country.

Four traditional financing mechanisms—public financing, user fees, private insurance, and national health insurance—are assessed in terms of their capacity to increase financial resources. Another set—complementary mechanisms—stresses policies that compensate for the unwanted social affects generated by the traditional mechanisms. The document recommends that public health services be supported by public financing. It concentrates on identifying alternative financing mechanisms for personal care that provide the combination most suitable to help achieve the multiple goals of health sector reform. Among the recommendations that resulted from the analysis and the shared experiences, the following are provided: (1) There is need for a prior assessment to be made concerning the potential to expand the tax base and the political viability for the public financing strategy. (2) User fees tend to be regressive and are not favored by most countries. However, they should not be implemented if the legal framework does not allow the sector to retain the resources. (3) Given the level of poverty in the Caribbean, private health insurance is a mechanism of little potential. (4) the national health insurance plans will be most effective if they balance health priorities with resources, define levels of care and a related package of services, and make provision for subsidizing premiums and user fees according to level of income. In subsidizing target beneficiary groups there is need for clear criteria, provision to ensure continuity of subsidy, and a rational way to phase them out without jeopardizing the poor. Also, provisions must be made through a strict billing system to ensure that the public sector does not subsidize the use of public services for private care.

A special Task Force advised on the mechanisms for linking decentralization and financing. Public financing of all forms of decentralization can benefit the poor, depending on how resources are allocated and whether the subsidies from public funding go to support the services used by the poor. Neither private insurance nor user fees are pro-poor. National health insurance plans have the best prospect for linking financing and decentralization to protect the poor. In the devolution model, single payer and global budgets are most appropriate. For it to be effective, regional funds and inter-regional transfers must be based on services offered. Under the delegated model the best strategy is to combine national health insurance based on global budgets with a targeted mechanism that establishes who receives the subsidy. The deconcentration model does not have the capability or the authority to implement independent financing mechanisms. It, therefore, requires good management practices by the MOH to achieve financial sustainability while protecting the poor. For the link to function effectively, regardless of what model is implemented, the MOH should participate actively in enhancing equity in health care by performing a steering role, establishing appropriate regulations, financing procedures for health expenditure and coverage, and for direct delivery of health services targeting the poor.
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INTRODUCTION

Many countries around the world are engaged in a process of health sector reform. The activities are generally influenced by wider public sector reforms that focus on a combination of changes in administrative, financial and service delivery arrangements. Five guiding principles of health sector reform have been internationally adopted: equity, quality, efficiency, financial sustainability and intersectoral action and community development (Annex 1). They form the benchmarks by which changes in the sector are monitored and measured. The Caribbean has engaged in various health care reform efforts for four decades. There is, however, evidence that the previously admirable public health standards are declining in some countries, certain communicable diseases are reemerging, and the quality of service is deteriorating. At the same time, an aging population, high levels of unemployment and the large number of poor households make it expedient for health sector reform strategies to take into consideration national plans for poverty reduction (Annex 2). Although each country has prioritized the guiding principles in different ways, decentralization and appropriate financial mechanisms comprise the most commonly shared health sector reform initiatives.

This project focuses on decentralization and health care financing, with special emphasis on how these processes affect access to care by the poor. Its aim is to identify policies and benchmarks in the design and implementation of both of these reform strategies that avoid unwanted and unfair effects on the poor. The results in this document are based on a concept paper prepared by the project resource group, consultations with country focal groups, official reports, and policy round tables held with senior policy makers and practitioners involved in the implementation of health reform strategies. These activities facilitated the systematic documentation of shared experiences among participating countries. The results of this exercise—reported in this policy document—are organized into four sections and respond to the following questions:

- **Background.** Why concentrate on decentralization and financing strategies? Why is it necessary to focus on protecting the poor as a special aspect of health equity?
- **Decentralization.** What is the context and form of decentralization being undertaken in different countries? How can the decentralization process be implemented in a way that ensures equitable access to services by the poor?
- **Health Care Financing (HCF)** Which financial options are feasible and also support equitable health reforms? Which of the HCF options that have prospects for protecting access to health services by the poor are being implemented?
Why decentralization and health care financing?

Decentralization is a process that has the potential to contribute to all five guiding principles of health reform. New financing strategies are receiving attention due to the urgent need to improve the efficient generation and allocation of scarce resources. Some countries, including The Bahamas, Dominica, Grenada, Guyana, and St. Vincent are placing emphasis on decentralization issues. Others, such as Antigua, St. Kitts/Nevis and Suriname, are emphasizing health financing; yet others, including Belize, Jamaica, Trinidad and Tobago, Barbados, and St. Lucia are pursuing both initiatives either jointly or simultaneously.

Decentralization and financing strategies are interrelated and changes in one affect the operation of the other. Countries involved in decentralization activities must consider the cost-effectiveness of the proposed decentralized system and address issues of financial sustainability. At the same time, the financing mechanism(s) chosen must be structured in such a way that they do not discriminate against communities or individuals that are poor or vulnerable. Often, plans for reform are well-laid but not implemented successfully. This may be due to any of several factors, including lack of human and institutional capacities, changes in government policy, variation in government commitment to reform or to the health sector, or high turnover within the Ministry of Health.

Who are the poor and why focus on them?

Definitions of poverty place emphasis on income, consumption or wealth. The poor are generally identified as those persons with insufficient income with which to satisfy their basic needs. Alternatively, they are those who cannot obtain and consume the food needed to provide the basic caloric intake required to sustain minimum health. Many countries in the Caribbean have official programs for reducing or eradicating poverty, based on a country specific measure which identifies the households that fall below the officially established poverty line (Annex 3). The high poverty rates in the Caribbean, which range between 7% of households in The Bahamas to 45% in Guyana, provide an additional reason for focusing attention on the needs of this group. Social investment and safety net programs directed at income generation and welfare activities for the poor usually only indirectly incorporate health sector issues. Improving the health status of the poor and vulnerable helps to make them more productive and capable of contributing effectively to society, but these benefits will not materialize unless the economic and social barriers that affect equity in access to health services for the poor and vulnerable are removed.

Economic barriers to health care services can be generally described as insufficient financial resources to purchase health care services. Over the past ten years, a number of living standard
measurement surveys and poverty assessments have been undertaken in the Caribbean. A report by
the Health Economics Unit, University of the West Indies, examined the data in these surveys in six
Caribbean countries, namely: Belize, Guyana, Jamaica, St. Lucia, St. Vincent and the Grenadines,
and Trinidad and Tobago. The study indicated that there were clear differences in access and
utilization rates for health services between the poor and non-poor. Twice as many of the poor as the
non-poor said that among the reasons for not seeking care when ill was lack of money (Annex 4). In
addition, the poor are almost invariably more dependent on public health facilities, which are
deteriorating because of the increasing financial strains currently experienced by most national
governments.

Social barriers to health services, reflected in such characteristics as poor living conditions, lack
of education and lack of employment opportunities, result in generally lower levels of health for the
poor than the non-poor. Studies have shown that, worldwide, the poor generally have a higher burden
of disease and higher death rates than do the non-poor. In recent years, a great deal of attention has
been given to the possible impact and role of life-style factors. Some studies show that people in the
lowest economic bracket are more likely to possess an array of biological risk factors (such as
hypertension), health behaviors, and psychological characteristics that increase the incidence of
mortality and morbidity. Unhealthy social environments and material disadvantage can combine to
seriously affect the health status of the poor. They are more susceptible to both communicable and
non-communicable diseases, and are disproportionately affected by the growing levels of violence
and injury.

Removing the economic and social barriers to equity in access to health care is a political decision to be
addressed in the public policy arena. Health Planning Units are essential to the process and should be
equipped to monitor trends in health status, the impact of health policies, and to advise on health priorities
based on reliable information and a viable method for analyzing the information.

**DECENTRALIZATION**

What is the context and form of decentralization being undertaken in
different countries?

Decentralization refers to a process by which the administration of health services or delivery sites
for health services that were initially under a central authority are shared by one or more sub-units.
The scope of decentralized units varies from country to country. Decentralization processes may
display on functional or structural characteristics, or may combine the two.

Functional Decentralization refers to a process whereby the responsibility and power, initially
under the central authority, is increasingly shared, or taken over, by one or more sub-units with the
capacity and capability to effectively manage the agreed-upon services.

Structural Decentralization, in contrast, identifies a process whereby health care provider sites
become more geographically distributed throughout the country. Multiple provider sites remove
geographical barriers to access, which is especially useful for rural and some inner-city urban
populations, which are mostly poor. However, structural decentralization has limited applicability in
the smaller OECS nations, where geographic access to care poses few problems, and in most other countries that already have high geographic distributions of provider sites.

The following discussion focuses on functional decentralization, which poses particular risks and challenges to health reform, especially in relation to maintaining a national commitment to reform goals. Under the traditional models of decentralization, the state maintains at least a regulatory role for both structurally and functionally decentralized units, which can help guide decentralized management toward reform goals.

Privatization of health care, whereby the state transfers the management of certain functions through statutory or corporate procedures is increasingly being advocated as an alternative to traditional models of decentralization. The regulatory role of the state is especially critical in privatized systems to maintain a focus on the health reform goals so as to avoid private sector norms of profit-making to predominate at the expense of other goals such as equity, quality and effectiveness.

Types of decentralized systems

Using the internationally recognized classification of decentralization, three basic types are identified with the Caribbean experience:

- **Devolution**— in which a sub-unit functions as an incorporated state agency with independent power to implement health programs agreed to in its charter.
- **Delegation**— in which a sub-unit functions as an unincorporated state agency with no charter of its own but has functions assigned by a central authority to coordinate an agreed set of health programs and projects.
- **Deconcentration**— in which a local organization without independent power is designated by the central authority to carry out specific health functions.

Some countries, however, have adopted a hybrid form of decentralization by combining the delegation and deconcentration models, in which the decentralized unit has functions designated by the central authority to coordinate an agreed set of health programs and projects. This type of decentralization in most OECS countries and in The Bahamas and Barbados shifts responsibility for the day-to-day management and operational functions of the health system from the highly centralized mode to autonomous regional and/or hospital boards. The experience in Grenada, St. Vincent and St. Lucia shows that because the Government transfers functions to hospital boards with varying degrees of regulation, it permits them to combine public and private roles. Without binding legal instruments to define the boundaries of this private/public relationship, the system has the potential to discriminate against the poor and vulnerable by placing emphasis primarily on efficiency goals. In some of the smallest states, such as Montserrat and Anguilla, which already have small administrative and delivery structures, traditional concerns generated by the effects of highly centralized structures do not apply. In these cases, decentralization is operationalized as the creation of mechanisms to facilitate public participation in decision-making while maintaining their
administrative and physical structures, demonstrating a sensible application of the decentralization principles to their particular countries’ situation.

Table 1, generated from the responses of the Country Focal Groups, provides positive and negative aspects of each model of decentralization. Some of the more notable implications for protecting the poor indicators are listed below:

- **Devolution** is the most independent and flexible model, especially in terms of recruitment of personnel and budget. Given the creation of a charter, it is difficult for the central administration to intervene even to address mismanagement or initiatives that diverge from national priorities, such as health sector reform goals. The system is dependent on the central and/or local government authorities for revenue since it does not have power to raise funds through taxation.

- **Delegation** is less risky than the devolution model. It is bound by specific instruments, which distinguish its roles and accountability from that of the central authority. However, it has no power to redirect resources to respond to local need, unless there is prior agreement by the central government.

- The **Delegation/Deconcentration** hybrid bridges the gap between public and private sector norms, creating responsibilities to simultaneously enhance efficiency and equity objectives. At the same time, there may be times that the competition between these objectives sends conflicting signals to stakeholders and clients, and result in the subordination of equity to another private sector norm, profit-making.

- **Deconcentration** facilitates including local inputs in the planning process, but its total dependence on higher levels for management and financial matters provides little motivation for developing innovative programs or maintaining viable ones.
<table>
<thead>
<tr>
<th>Type of Decentralized System</th>
<th>Positive Aspects</th>
<th>Negative Aspects</th>
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<tbody>
<tr>
<td>Evolution: Independent government structure</td>
<td>Most independent and flexible structure capable of identifying local priorities for action and rearranging resources to fit local needs</td>
<td>Central government does not always require compliance with its instructions</td>
</tr>
<tr>
<td>Jamaica</td>
<td>Previous bureaucratic rules and procedures least bind this structure</td>
<td>Difficult for central administration to intervene, even to avoid mismanagement other problems</td>
</tr>
<tr>
<td>Trinidad and Tobago</td>
<td>Most empowering structure for local communities</td>
<td>Normally dependent on another level of government for revenue since it does not have taxing power</td>
</tr>
<tr>
<td>Guyana</td>
<td>Local government is an asset</td>
<td></td>
</tr>
<tr>
<td>Delegation: Unincorporated delegated structure</td>
<td>Less risky (than devolution) for the central government and less risky to the public in the event of a breakdown in local management and program delivery</td>
<td>Has potential for flexibility and for sensitivity to local needs but no power to redirect resources according to local need unless agreed to by the central government</td>
</tr>
<tr>
<td>Suriname, Dominica</td>
<td>Sometimes used as a first step to devolution</td>
<td>Does not necessarily overcome the impediments of rules and controls of the central authority</td>
</tr>
<tr>
<td></td>
<td>The key to its flexibility is in the rules and agreements in the instruments of delegated power</td>
<td>Only offers the benefits the central administration allows it to explore</td>
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<tr>
<td></td>
<td>Local structures are in place but centralized functions are in operation</td>
<td>Remains organizational dependent</td>
</tr>
<tr>
<td>Delegation/Deconcentration:</td>
<td>Specific focus and targets lead to clarifying goals within the dual system</td>
<td>Conflicting objectives can lead to confusing signals to stakeholders/clients</td>
</tr>
<tr>
<td>Incorporated with delegated structure for public and private roles</td>
<td>Bridges role between public and private sector norms</td>
<td>Possible trade-off between profit-making and equity to the disadvantage of the latter; De-linked from the integrated system, which can lead to isolation</td>
</tr>
<tr>
<td>The Bahamas, Barbados, Grenada, St Vincent</td>
<td>Can pursue efficiency and equity objectives simultaneously</td>
<td></td>
</tr>
<tr>
<td>Deconcentration: Local advisory structure</td>
<td>Allows local input and opinion on programs and health delivery systems</td>
<td>If the plans and suggestions are not eventually used, the quality, motivation, and performance of the structure will decline</td>
</tr>
<tr>
<td>Belize</td>
<td>Can be a local planning body without having the responsibility for implementing programs</td>
<td>There is no inherent pressure in this structure to be viable or to possess the attributes for acceptable public implementation</td>
</tr>
<tr>
<td>Montserrat</td>
<td>Can be a focal point for identifying and training local people to participate in the health system</td>
<td>It is totally dependent</td>
</tr>
<tr>
<td>Anguilla</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Risks and possible solutions

Recognition of challenges based on others’ experiences can greatly improve the chances of successful implementation of decentralization while demonstrating commitment to other reform goals. Most important is the acknowledgement that some decentralization models will not benefit all countries due to the specific characteristics of each. One of the worst risks of mismatching models to countries is the potential for discrimination against the poor and other vulnerable groups, even when implementation of the model is technically successful. This may be due to national or local governmental structures, incentives for provision of care, patterns of funding flows, or even the competition for funds or personnel that can be generated through decentralization. The particular profile, needs, and priorities of a country should guide decisions regarding which decentralization approach, if any, is most appropriate. Table 2 is based on the shared experiences among the countries, which underline that the reasons for most of the risks are associated with management failure; lack of economies of scale for purchasing supplies and equipment and information gathering; lack of human capacity, and added infrastructure and operational costs.

The creation of multiple administrative or physical structures can be costly due to several factors, including the investment in new facilities, additional levels of management, additional personnel, and training. Creative thinking can reduce costs, though. Jamaica and Trinidad and Tobago, for example, minimized infrastructure capitalization costs by locating some regional health authorities within the existing public hospital facilities, while others were accommodated in leased or rented space.

The following aspects of each decentralization model are not insurmountable, but constitute specific challenges or potential advantages for each model. Careful planning and implementation can maximize positive aspects and control negative ones. The table does not cover every possible characteristic of each model, but is intended to draw attention to some of the more common experiences within each model.

Size, population density, and existing forms of local government help to determine the appropriate form and type of decentralization for a particular country. Dominica, for example with a population of fewer than 75,000 and a landmass of less than 150 square miles, is an illustration of how difficult and costly it is to implement and sustain a decentralized health care system. An analysis of costs shows that approximately 30% of the overall public health budget goes to maintaining the decentralization program. This high level of investment in decentralized health care services is comparable only to Jamaica and Trinidad and Tobago, where the overall allocation is expected to be approximately 33%. The result of this investment in Dominica is to place emphasis on community participation in local health centers and improve access by the poor and vulnerable to preventive as well as curative health care services.

The major risks of the delegation and deconcentration models are related to the difficulties they experience in generating adequate health revenue, investing in human resources and infrastructure, and controlling special interest groups. The case of Barbados, for example, illustrates how important and beneficial it is to create and sustain particular economic and political environments in which to promote universal access to services. Their approach includes the distribution of publicly funded resources for the poor such as pharmaceuticals and diagnostic services, benefits not usually enjoyed by vulnerable groups, but nevertheless integral to any comprehensive universal system of care.
<table>
<thead>
<tr>
<th>Classification of Risk</th>
<th>Type of Risks</th>
<th>Policy to Minimize Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health revenue generation</td>
<td>Uneven revenue-generating capacity among regions, Poorer areas invest less in health, Programs are required to overcome their disadvantaged position</td>
<td>Establish a standardized national mechanism for identifying the beneficiary population that applies to health and other social sectors</td>
</tr>
<tr>
<td>Resource allocation at the district level</td>
<td>Flexibility in award/use of resources no guarantee of better cost/benefit, Direction of programs and allocation of resources likely to be captured by the affluent, bureaucrats and health professionals</td>
<td>Involve consumer in program planning and priority setting, Provide support to facilitate the involvement of poorer consumers</td>
</tr>
<tr>
<td>Human capacity (professional and consumer)</td>
<td>Lack of adequate technical skills, Difficult to decentralize some specialized functions, Incorporation of existing public health employees and officials may hinder ability to benefit the poor</td>
<td>Redesign job content or site location of the decentralized staff</td>
</tr>
<tr>
<td>Added infrastructure costs</td>
<td>New structure has to be created unless there is a pre-existing structure, Consumption of scarce resources in new administrative activities</td>
<td>Compare the benefits of establishing new administrative activities with using existing facilities. For example, regional hospitals</td>
</tr>
<tr>
<td>Control by special interest groups</td>
<td>Possibility that responsiveness of government to the poor may be decreased due to pressure from groups opposed to decentralization</td>
<td>Introduce a scheme that will avoid a power grab of resources by powerful interests that would work to the disadvantage of the poor</td>
</tr>
<tr>
<td>Economies of scale (size and function)</td>
<td>Small countries will not reap benefits of decentralization, Multiple structures/functions may be too costly (per capita)</td>
<td>Make decision on how to modify current centralized system to assist effective administration rather than convolution of resources</td>
</tr>
<tr>
<td>Political</td>
<td>Moving from a global budget to a decentralized budget reduces accountability of the central government with respect to special programs for the poor, Decentralized authority tends to transfer responsibility for expensive care to the central authority</td>
<td>Establish clear guidelines of authority/accountability between central and decentralized systems</td>
</tr>
<tr>
<td>Trade-off arising from Intersectoral collaboration</td>
<td>Health priorities may be sacrificed in the competition for limited funds</td>
<td>Identify one or two key issues that link other sectors to health promotion and prevention, Prioritize any health activities that cannot be intersectorally linked</td>
</tr>
</tbody>
</table>
The benefits of matching decentralized units with systems of local government are not always realized. The experience in Guyana is that when there were several functions administered at the district or regional level, then money intended for health services was at times redirected toward other public services, leaving health priorities unfulfilled. One way to prevent such occurrences is to delink the decentralized health system from the local government structure, as is now being proposed in Guyana, and make the community health system the dominant unit. This presents the possibility for fostering a new management group drawn from a broader range of practitioners and citizens concerned with improving community health. Incorporating providers and other health workers into this process is critical to minimizing the risks of decentralization.

**How can decentralization protect the poor?**

Most countries agree that for decentralization to assist in removing the barriers to quality health care for the poor, the following two-stage approach is required:

<table>
<thead>
<tr>
<th>Stage 1. Ensure that the decentralization process works</th>
<th>Stage 2. Establish specific mechanisms to target the poor</th>
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</table>

- **Stage 1.** Ensure that the decentralization process works
  - Identify needs and priorities that will drive the selection of the decentralization strategy [Jamaica and Trinidad and Tobago].
  - Develop a communication strategy targeted to the public, the powerful interest groups, and the health professionals, which requires an investment in face-to-face discussion and dissemination of information [Jamaica, Barbados, St. Lucia].
  - Invest in educating and training the new board and staff members of the new regional authorities to function effectively within the community system.
  - Reorganize labor relations by fostering a better consultative and collaborative climate between the health workers, their unions, and the health corporations in the implementation of the new system [The Bahamas].

*Require the state’s approval for the provision of highly specialized essential services, such as magnetic resonance imaging (MRI) to be provided by the private sector and for the government to purchase these services for regional health authorities and other community health care centers when required [Barbados]*

<table>
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<th>Stage 2. Establish specific mechanisms to target the poor</th>
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- **Stage 2.** Establish specific mechanisms to target the poor
  - Emphasize needs-based financing by targeting government subsidy for public health and health care delivery to vulnerable groups [Barbados].
  - Directly target the health needs of the poor and vulnerable groups, which involves allocating human, physical, and financial resources to favor those who fall within a standardized measure of poverty within a country [Barbados].
  - Manage the increase in access and utilization of health care, and increase the use of preventive care services by the poor.
  - Realign spending from institutions to communities by allocating funds-based programs, removing the barriers to palliative care at home, and reducing the number of hospital beds. Planning should take into consideration the living conditions of those patients from lower income groups [Barbados].
  - Pursue strategies to achieve financial sustainability using a needs-based funding formula for the basic package to the poor.

*Make provisions for coverage of the poor when contracting private health services with public funds [Barbados]*

The strategies associated with each stage are based on experiences of different countries. The experience of Canada suggests that the implementation of all stage 1 strategies will facilitate the
implementation of stage 2 strategies. For example, a health reform unit was established in Jamaica to develop the blueprint for overall reforms and to pilot the strategies necessary to ensure their successful implementation. A minimum requirement is to set up a viable planning unit within the Ministries of Health.

Decentralization, privatization, and protecting the poor

The Country Focal Groups agree that the for-profit private sector is unlikely to play a major role, if any, in the decentralization process and is less likely to focus on the poor than the non-profit private sector or public sector. However, there are some examples of private health care services within local communities with potential for removing barriers for the poor. One example of this is the medical services attached to the sugar estates in Guyana, which also extend services to the communities in which they are located.

Responsibilities for services may be shared between the public and private sectors. In Barbados, for example, partnerships are being developed whereby the private sector operates certain services—geriatric and high-tech services—which the government pays to access on behalf of the poor and vulnerable. This arrangement permits these services to be available without requiring the government to make the capital investment that would be required to deliver them.

NGOs are involved in the delivery of health services that protect the poor. The extent to which these efforts are sustainable vary from country to country.

HEALTH CARE FINANCING

Financial reforms in the health sector similar to those in the overall economies of the Caribbean were triggered by financial restrictions. There were initially few, if any, policies specifically designed to protect the poor. Country studies during the implementation of this project confirmed the conceptual notion that a sound combination of financing mechanisms would best help to achieve financial sustainability and at the same time improve access and utilization of health services by the poor.

Health Care Financing (HCF) refers to the identification of sources of financing and the allocation of resources to finance the provision of health services. At the country level, an HCF strategy is expected to include financing for personal care as well as public health interventions, which have the characteristics of public goods. One of the distinctions that defines a public good is the existence of positive externalities; that is, benefits of consumption are not exclusive to the consumer. A number of public health interventions are public goods and therefore require that a threshold level of coverage be achieved in order for benefits to be accrued at the society level. For example, a successful immunization program requires that the susceptible population be reduced to a
minimum level; and control of diseases transmitted by vectors also entails the implementation of vector control programs that cover all of the housing of the population at risk.

In general terms, public goods pose a problem for charging individuals the cost of consumption, a difficulty referred to in the literature as the problem of the free-rider. The pertinence of public finance for commodities of this kind has been well documented in the Public Finance field and is supported in this policy paper. The rationale is that individual financing would result in a level of consumption lower than the socially desirable.

The final outcome in the health sector and success in achieving health sector reform goals will be determined by the outcomes at the following three levels of financial flows.

- **Financing**, which includes the sources of expenditure for the health system as a whole.
- **Funding**, which refers to the allocation of resources within the health system, usually through payments to public or private institutions.
- **Remuneration**, which is the actual compensation to individuals who are employed in the health system.

Provider payment mechanisms refer to the manner in which financial resources are allocated from the funding agency, whether Government or private insurance groups, to the health care provider. Each provider payment mechanism has implicit incentives and financial risks that influence providers’ behavior and therefore the final outcome. Providers’ decisions on quantity and quality of services are directly influenced by the manner in which they get paid. Therefore, these mechanisms have a direct impact on the performance of the Health System as well as on the achievement of efficiency, equity and quality.

While recognizing the relationships between the three levels of financial flows, this document focuses on the first. Some consideration is given to provider payment mechanisms, in a manner that complements the orientation to analyze the implementation of a financing strategy.

The Caribbean experience of introducing changes in health care financing exemplifies the importance of designing and implementing an HCF policy adequately informed by the potential impact of each possible financing mechanism. A preliminary assessment of how they will interact when combined in different ways will also facilitate better-informed decisions. The actual implementation process will determine to what extent expected results are achieved. This section of the paper concentrates on the discussion of alternatives to finance the provision of health services that have the characteristics of personal care and addresses mechanisms and options in designing and implementing HCF policy.
The changes in the last fifteen years that have taken place in health care financing in Latin America and the Caribbean were responses to the need to close the gap left by reduced public resources in the social sectors. The modifications to health care financing in the region began with a sense of urgency. The immediate response of public sector providers was to identify and implement a variety of financing mechanisms to compensate for the reduction of public expenditure in health. The implementation of these financing mechanisms was aimed at the single most important objective of mobilizing resources. Consequently, most of these changes were introduced without prior assessment of the impact on access to health care or any of the current guiding principles of the health sector reform. Annex 5 presents economic data relevant to the discussion on health care financing.

The experience of implementing financing mechanisms in an isolated manner proved to be counterproductive when more than one objective was pursued. For example, the introduction of non-differentiated (flat) user fees has become the classic example of a financing mechanism that presents problems for equity. It generates cash flow, but it discriminates against the poor. In this case the objectives of financial sustainability and equity cannot be achieved simultaneously.

The real challenge of health sector reform is to organize the use of different financing mechanisms as a strategy to address the financial and equity requirements of the countries’ populations. The HCF strategy should identify suitable sources and uses of resources to finance personal care services as well as public health interventions. It needs to be designed within the framework of each country’s macroeconomic and social policies.

The design stage of the HCF strategy will benefit from adequate information on actual costs of delivering health care services. When cost recovery schemes are under consideration it is crucial to assess the population’s ability to pay in order to estimate the impact on access and potential revenue. The implementation phase may require additional financial resources to start up the system. Therefore, it is relevant to have an accurate estimation.

**Is there a funding gap?**

A funding gap occurs when financial resources for health are not sufficient to cover the costs of providing the health services required by the population. The notion of a funding gap is based on the existence of an insufficient level of resources to cover a particular set of health needs. Some attempts have been made to estimate this gap by comparing increases in health care cost to actual expenditure in the sector. However, country focal groups in this project indicated that increasing productivity of resources involved in the process of health care delivery could reduce the gap where it exists. One method of estimating the financial gap is to examine the share of health expenditure in Gross Domestic Product (GDP). However, this does not guarantee the quality, level of care or equitable distribution of health services. Hence the gap measured in this manner is an indicator of little value for policy decisions.
Each country should make its own calculation of the funding gap. Estimation should be based on a specific health plan, considering all the available financial resources, including the costs of services and identifying opportunities to improve productivity in the sector.

Because health sector activities may be supported by funds generated from a number of sources, all funds should be included in planning activities. However, many types of funds such as loans and grants from international funding sources cannot be considered to be part of a sustainable program beyond the commitments that have been made. The distinction between these sources, and the programs that are dependent on them, should be made explicit in the planning stage.

Develop a realistic budget that takes into account both governmental and non-governmental resources, and addresses the sustainability of those resources.

What are the mechanisms of HCF?

Countries have implemented a number of health care financing mechanisms and are undertaking studies to assess the pertinence of implementing others. A summary of such mechanisms is presented here. It includes an analysis of the potential of these mechanisms to support health sector reform goals and identifies combinations that maximize the outcome. They are divided into traditional and complementary mechanisms. The first group has the potential to increase financial resources, while the second stresses policies that compensate for the unwanted social effects generated by traditional mechanisms.

There are four main traditional mechanisms of financing, namely (a) public financing (b) user fees, (c) private insurance, and (d) National Health Insurance. Complementary mechanisms refer to any form of subsidy to reduce financial barriers to accessing health services. The discussion that follows illustrates the potential that each financing mechanism has to contribute to the financing of personal care services within the stated objectives, including financial sustainability as well as other health reform goals. The document has already proposed that public health interventions be financed through public funding.

Traditional financing mechanisms

Public financing

Prior to the movement toward economic liberalization in the Caribbean, public financing was the main source of health financing. This is consistent with the concept of the welfare state by which the public sector was considered to be responsible and had the resources for financing social services. By the 1980s public financing ensured a relatively good health status for the population, sometimes even better than that achieved by countries with higher national incomes.

Relying exclusively on public funding places health in competition with other sectors for budgetary funds. Additional resources from public financing may be generated by reallocating public
expenditure from other sectors to provide a higher share to health, or by implementing new taxes which can be earmarked to finance health. Both options have policy implications beyond the health sector and give rise to a discussion that takes place in the wider public finance policy arena. The first proposal calls for resetting priorities in public expenditure. The second raises a discussion on the feasibility of expanding the existing tax base of the country, which may not always be possible. For instance, studies conducted in the design phase of the health sector reform project in Jamaica indicated that it was not feasible to get additional resources for the health sector through taxes. In Barbados discussions over the past years on the possibility of introducing taxes earmarked for health, have been overtaken by the implementation of a value added tax of 15%, which goes to support the Social Investment Fund, part of the country’s poverty alleviation strategy.

Determine if it would be appropriate and/or feasible to reallocate public funds to health from other sectors, or to expand the tax base by implementing new taxes earmarked for health. This analysis has to be conducted within the framework of the macroeconomic policy of the country.

**User Fees**

User fees were reintroduced in the 1980s as the most feasible HCF mechanism to supplement public financing because the legal framework to adopt them had been developed during a previous period. In theory, this mechanism has the potential to increase revenues if applied to commodities with low price elasticity, which is the most likely situation in health care. Additionally, it could be argued that requiring the financial participation of members of the society who are able to pay enhances equity by allowing better targeting of public resources for appropriate populations.

Although most Caribbean countries have implemented user fees for purposes of cost sharing, in practice, the results have been relatively ineffectual. They have not generated any discernible increase in revenue, and in fact have increased the administrative burdens on the public health system. There are several reasons for this situation. First, an effective collection system has not been implemented in most countries, with the possible exception of Jamaica. Second, user fees have become an additional barrier to access to health by the poor, and hence have proved to be regressive. Third, there is no systematic formula for granting exemptions on the basis of inability to pay for services. Fourth, the implementation of user fees has necessitated the reallocation of personnel from provision of health care to the administrative tasks of fee collection and assessment for exemptions.

In the Eastern Caribbean countries and in other parts of the region, regulations do not allow the public Health System to keep the monies collected. Any amount collected becomes part of the central government revenue, so there is no increase of financial resources effectively available for the provision of health care services. Under these circumstances, the health sector is undertaking the activity of collection of public revenue, for which it has neither a mandate nor a comparative advantage. Thus, it has become an additional source of misallocation of public resources. The implementation of user fees has hindered the achievement of equity and efficiency. This subject was intensively discussed at the policy round table (May 1999) and the conclusion, with the exception of Jamaica, is that user fees have no potential to make a positive contribution as part of a Health Care Financing strategy.
If countries decide to implement a user fee system, some critical issues must be carefully addressed. These include a prior assessment of the impact of user fees on access to health services, and mechanisms for correcting unwanted effects. Incentives for collection would also have to be identified and established.

An effective and enforceable system of fee collection hinges on several features:

- Collection of fees by someone other than health providers, such as administrative support personnel.
- Clear policies regarding the division between the public and private sectors.
- Development of an adequate mechanism to bill private insurance companies for coverage of their clients.
- Establishment of clear criteria for exemption (exemption categories typically include those based on income, disease, and services).
- Identification of beneficiary populations by someone other than the local health providers, such as a centralized mechanism linked to other safety-net programs.
- Dissemination of information to exempted populations regarding exemption eligibility.
- Mechanism to reimburse providers for revenues lost to exemptions.
- Uniform application of guidelines and standards.

**Private Health Insurance**

Private insurance is the most likely complement to public finance. However, it presents all of the problems arising from a scheme based on pooling risk and managed as a for-profit venture. Participants in a private insurance scheme are required to pay a premium calculated on expected patterns of utilization for health services. Therefore persons who suffer from chronic diseases, which are considered pre-existing conditions, would be required to pay premiums that make the scheme not financially feasible for them.

The feasibility of private insurance as an effective coverage mechanism depends on issues such as having a sizable population with high-income levels, competition within the private sector, and continued support of the public sector to subsidize those who cannot afford insurance. Since ability to pay is determined by household income, experience shows that low-income families have difficulty participating in such schemes. Private insurance covers less than 25% of the population and an even smaller portion of the primary medical/curative expenses in the Caribbean. Given current poverty rates, the development of this financing option appears limited for now, and it may not be realistically considered in a strategy for health coverage for the majority of the population.

The Bahamas has the most extensive coverage through the private sector and reports coverage rates around 40% of the population, with increasing growth and demand. In Jamaica, private insurance covers around 14% of the population, but there are variations in coverage and small businesses usually cannot purchase insurance. Some countries like Barbados and Antigua and Barbuda expressed their belief that—if properly managed—private insurance can be a viable option for their economies.

Because private insurance is enjoyed by the wealthier sectors of the population, both intended and incidental public subsidies of such care pose a particular problem for protection of the poor.
Even given the current limited development of private insurance, in practice, coverage is subsidized by the public sector, due mainly to the fact that the public sector does not have a well-defined system to bill the insurance companies when services are rendered by public providers. Billing procedures and systems would have to be established to effectively integrate private insurance into the health care sector.

Establish billing systems and regulations to control public subsidies to patients who are covered by insurance.

**National Health Insurance**

A National Health Insurance Program (NHIP) is seen as the financing scheme with the highest potential to positively affect the poor and to ensure wide coverage and sustainability. It could also be an important equity-enhancing instrument since it could be predicated on ability-to-pay. Annex 6 presents the design of an NHIP that has the potential to improve both the health status of the population and the level of health security by ensuring that access barriers on both the supply and the demand side are removed. It illustrates a system funded by families through premiums based on family income and complemented by public financing. The latter is aimed at covering the difference between the cost of service and the income adjusted premium and co-payment subsidy for the poor and medically indigent according to the established definition in each country. This approach provides an opportunity for public resources to be targeted to those with the greatest need.

The implementation of an NHIP requires significant human and financial resources. It identifies a set of priority benefits that actually can serve the entire population and premiums based on ability to pay, such an approach provides a highly rational and equitable distribution of health care services. However, if an NHIP is not implemented under conditions of sufficient planning, management, and financial support, this approach could waste already scarce resources and further undermine priorities.

On the basis of shared experiences, recommendations were made concerning appropriate strategies in the design and implementation stages of an NHIP.

**Design Considerations in an NHIP:**

- Establish sufficient planning, management, and financial support to develop an NHIP that balances health priorities with available resources.
- Define the level of care and package of services to be covered by the NHIP (for example, primary care, secondary care, and others.)
- Identify the level of participation of employers in funding insurance premiums (note: the impact of this on the labor market must be considered in making this determination).
- Establish provisions to subsidize premiums and co-payments according to incomes.

Due to the enormous technical challenges of implementing such a program, linking the national health insurance program to other forms of social insurance or by introducing benefits in stages would increase the potential for success. For instance, Grenada is considering linking the NHIP to its existing National Insurance Program to reduce infrastructure costs.
At least two other countries—Antigua/Barbuda and Bermuda—have universal but limited forms of national health insurance. The former country covers a limited number of chronic conditions while the latter covers a standard hospital package. Belize is at an early stage of developing an NHIP, and is studying its financial feasibility and determining the level of services that might be provided. Belize, St. Vincent and the Grenadines, and Jamaica are considering mandatory employer contributions or income-based contributions with exemptions for the poor. Suriname’s State Health Insurance has covered civil servants since 1981, and is considering expanding coverage to the entire population, although they claim that there is insufficient funding to maintain current benefit levels, which could present a problem in terms of political feasibility. The Bahamas is currently considering the possibility of an NHIP, Guyana is not, and Barbados remains skeptical about the potential for success that such a mechanism presents for Caribbean countries.

<table>
<thead>
<tr>
<th>Implementation Considerations in an NHIP:</th>
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<tbody>
<tr>
<td>♦ Introduce the program by linking it to existing national insurance programs.</td>
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<tr>
<td>♦ Introduce the program in stages.</td>
</tr>
<tr>
<td>♦ Consider if it is politically feasible as well as technically achievable.</td>
</tr>
<tr>
<td>♦ Examine if the proposal will decrease services to current subscribers of other health insurance programs.</td>
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</table>

**Complementary financing mechanisms**

**Subsidies**

Subsidies are an essential aspect of any health care financing strategy that seeks financial sustainability and improvements in health status. Accordingly they are considered to be complementary to traditional mechanisms in the HCF strategy. Subsidies can take the form of either vouchers for families to pay for health care, or direct payment to providers to compensate for the reduced payment by the target population. The purpose of this component of an HCF strategy is to compensate vulnerable groups from the effects of financial barriers that reduce their demand for health care. For the purposes of this document subsidies have been divided in two groups: those directed to the poor and those aimed at protecting other vulnerable groups.
**Subsidies to the poor**

This complementary financing mechanism includes any form of subsidies to which the poor are entitled in order to reduce the financial barriers to accessing health care services. Beneficiaries may be targeted in either of two ways. Narrow or highly accurate targeting identifies individuals or families as beneficiaries and has the advantage of low leakage while the identification process may be expensive. Another option is to follow the criteria of broad targeting, by identifying population groups with particular characteristics. While broad targeting is much less expensive than narrow targeting it is also less accurate, increasing the probability that benefits leak to populations not intended as beneficiaries.

| The decision on which targeting approach to use should be related to: |
|♦ Geographical concentrations of poverty, where high concentrations of poverty indicate a broad targeting approach and highly distributed income groups require narrow targeting. |
|♦ Administrative capacity to target individuals or families. |
|♦ Political feasibility of a narrow targeting approach, since leakage often reduces public resistance. |

In both cases, provisions should be made to ensure that eligibility criteria do not create arbitrary decisions on qualification but instead focus on need. The identification process must ensure that populations meeting the eligibility criteria are not excluded. Such exclusion may be due either to a lack of capacity to appropriately identify the target population in the case of narrow targeting or on the basis of broad targeting because beneficiaries do not live in areas where poverty is highly concentrated.

Differentiated fees have been used as one way of subsidizing the poor. However, countries' experiences show clearly that providers face logistic problems in identifying the beneficiaries of a reduced fee. The process can be made more efficient if it is part of a larger poverty-targeting project and is tied to other social sectors. In Jamaica, for instance, beneficiaries of health subsidies are identified using the same criteria and in the same process as identification of food stamp recipients.

Consider combining health sector targeting with targeting in other social sectors. Be careful to consider any weaknesses in the existing process, or special needs that would indicate a need for different criteria.

When subsidies take the form of exemptions for user fees, other issues must be addressed. For instance, if local budgets and provider remuneration are related to generation of revenues at the local level, health care providers must be compensated for revenues lost due to reduced payments of fees. Otherwise, providers will have incentives to discriminate against patients exempted from paying fees.
Develop Mechanisms to reimburse providers for income lost due to user fee exemptions. Subsidies should be paid from public funding and not by the provider.

Subsidies to other vulnerable groups

Another way to protect vulnerable groups from financial barriers is to make the provision of subsidies based on criteria other than poverty. In these cases, the criterion for eligibility is belonging to a specific group identified as vulnerable.

One example of subsidization not based on poverty but on medical need is the Social Benefit Scheme in Antigua. In this case, beneficiaries qualify for subsidized access to medical care if they suffer from one of nine priority diseases. Similarly, the Barbados Drug Service was established to improve access for the vulnerable populations by expanding distribution networks for drug services. Subsidized groups include those over 60 years, those less than 16 years of age and those with chronic diseases. Officials suspect abuses at the level of dispensing prescriptions but have no procedures for identifying the beneficiary population. Jamaica has implemented a drugs for the elderly program which aims at ensuring that they have adequate access to medications through subsidized prices.

Most Caribbean countries are reviewing their HCF strategy and assessing the pertinence of implementing a different combination of financing mechanisms. Table 3 summarizes the advantages and disadvantages of each mechanism as well as recommendations for their effective use. The appropriate combination of these mechanisms constitutes the basis for a sound financing strategy.

Additional Issues for Consideration

Two other issues emerged from the country reports as crucial to financing strategies: the overlap between the public and private sectors in medical services and the possibility of contracting-out certain limited services to the private sector.
<table>
<thead>
<tr>
<th>Financing Mechanism</th>
<th>Features</th>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Financing</td>
<td>Indicates commitment from macroeconomic policy. It establishes a general social commitment.</td>
<td>It facilitates targeting of social expenditure.</td>
<td>IT IS CYCLICAL WITH ECONOMIC ACTIVITY.</td>
<td>Prior assessment of potential to expand the tax base, and its political viability.</td>
</tr>
<tr>
<td>User Fees</td>
<td>It has the potential to generate contributions according to patient’s ability to pay.</td>
<td>It allows charging patients with insurance. Depending on legislation, may help increase resources available at the facility level.</td>
<td>It negatively affects decisions to seek care; may discriminate against the poor if exemption and collections are not properly implemented.</td>
<td>Should not be implemented if legal framework does not allow keeping resources within the sector. Design and implement adequate collection system. Set clear criteria for exemption and reimbursement for provider. Bill patients with private insurance.</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>Potential for implementation depends on family income and competition in the private sector.</td>
<td>If adequately implemented has the potential to decrease government subsidies to the non-poor.</td>
<td>It does not have the potential to cover the poor or patient with chronic diseases.</td>
<td>Billing systems must be developed and used to control public subsidization through provision of private services in the public sector.</td>
</tr>
<tr>
<td>NHIP</td>
<td>Funded through combination of (progressive) employee/employer contributions and subsidies.</td>
<td>It has the potential to enhance equity through universal access to care.</td>
<td>Requires substantial planning, political feasibility, prioritization—budget may not provide sufficient level of services to satisfy non-poor, may need to be supplemented by other financing mechanism.</td>
<td>Balance health priorities with resources, define level of care and package of services, identify participation of employers, and subsidize premiums and user fees according to incomes. Link program to existing national insurance programs or introduce it in stages.</td>
</tr>
<tr>
<td>Subsidies</td>
<td>Targets groups for benefits.</td>
<td>Can enhance equity by compensating for financial barriers.</td>
<td>Can present political challenges and implementation difficulties.</td>
<td>Set clear criteria for selecting target population. Establish provisions to ensure continuation of subsidies or a rational way to phase them out without jeopardizing the poor.</td>
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Provision of Private Services in Public Facilities

Almost every country reported that physicians use public facilities and time to conduct private practice without compensating the public sector for use of the facilities or reduced work hours. This directly reduces the level of efficiency, quality, effectiveness, and equity in the health system, and encourages unintended, uncontrolled rationing of services. Such rationing can operate at the expense of the poor when private patients jump public queues or increase waiting times for public patients. Presently, this practice is widely if not officially recognized as a way to complement low remuneration of providers, and functions inappropriately as a policy decision. This practice constitutes an important barrier to a fair distribution of resources and public control of public resources, and must be addressed within health sector reform.

Eliminating unsanctioned subsidization can be accomplished through:

♦ developing appropriate and transparent physician remuneration policies so that unsanctioned subsidization becomes unnecessary and is effectively discouraged,
♦ charging physicians for private practice within public facilities,
♦ establishing demarcations between the public and private sectors,
♦ billing insurance companies for services provided in public facilities to patients with private insurance,
♦ developing solutions in consultation with physicians and health care providers to ensure cooperation and enforcement of agreed policies.

Contracting Services to the Private Sector

There are some services that are publicly funded within the health sector that might be more efficiently provided by the private sector without threatening goals for health care reform. These include non-medical and non-health support services, such as laundry and food services in hospitals. For instance, in an effort to overcome some of the challenges to fee collection posed by the country’s small social scale, Belize is considering contracting-out fee collection to the private sector.

Medical and health services might also be contracted out in some circumstances. Barbados has begun to partner the public and private sectors for medical/surgical ambulatory visits, laboratory tests, prescriptions, and other services, proposing that such measures could increase efficiency while securing equity insofar as those services would be subsidized for the poor by the public sector. Because these services directly relate to care, implications for quality constitute greater concerns in this area, and periodic evaluations for the purposes of contract renewal should be integrated into administrative structures.
When considering contracting-out services to the private sector:
♦ **Perform a financial assessment to determine if it would be convenient and appropriate to contract-out support services rather than having them provided by the public sector, given current levels of competition and quality within the private sector.**
♦ **Determine whether there are health services that could best be served by the private sector.**
♦ **Assess whether the public sector has the resources and payment mechanisms in place to fulfill its contract, especially in relation to ensuring that the cash-flow will be sufficient to pay providers on time.**
♦ **Establish criteria and schedules for periodic evaluation of services to determine appropriateness of contract renewal.**

**THE OVERLAP BETWEEN DECENTRALIZATION AND FINANCING**

Several issues cut across all aspects of health reform and create a basis for activities such as decentralization and financing to be implemented more efficiently and effectively while protecting access to the poor.

A health plan aimed at linking decentralization and financial requirements must consider the following issues:

- Health needs and priorities of the population in relation to their socioeconomic status.
- Financing strategies for health sector reform on the basis of actual costs of services offered.
- Transitional costs in moving toward the appropriate decentralized system; and estimates of the available financial resources under the preferred financial strategy.
- Public subsidies that are to be allocated to cover the cost of health care for those unable to afford such care.

There is a difficulty in establishing the ideal fit between the decentralization and financing strategies. Budgeting and financial incentive structures provide a prime example of how decentralization and financing can combine to either protect the poor or discriminate against them.

A special working group of this research project considered the link between decentralization and financial strategies required to protect the poor. It was agreed that the best approach is to identify the financing option that is most appropriately associated with each of the four models of decentralization and the conditions that will facilitate efficient implementation.
Some principles for combining decentralization and financing

- Local incentives to generate revenue would seem to be an effective way to increase collection of user fees, but if local budgets rely heavily on such revenues, the structure will discriminate against poor communities and the facilities that serve them, which often have the most medical need of resources.
- Provider payment mechanisms must compensate for income loss due to providing service to patients exempted from co-payments or user fees to prevent social barriers to service for the poor.
- Competitions for funding can effectively exclude poor communities if they do not have the informational basis or human resources to submit a strong application, even when they have strong need for and deserve the funds.

When equity is sought through protecting the poor, the most successful financing strategies are public funding and national health insurance. Neither private insurance nor user fees are pro-poor. Public financing for all forms of decentralization can protect the poor depending on how resources are allocated and whether the subsidies from public funding go to support services that benefit the poor. National health insurance programs pose great potential for linking financing and decentralization to protect the poor. Hence it is necessary to examine the expected outcomes of various models of decentralization when combined with an NHIP.

Devolution/financing option
Single-payer and global budgets are most appropriate for the devolutionary model of decentralization. To function effectively at the level of the hospital authority, this model requires a strong Ministry of Health with planning and regulatory capacities, a restructured health delivery network of hospitals, a defined basic package, and provider-paid fees that are periodically negotiated. To function effectively at the level of the regional health authority, the model requires a formula for allocation of regional funds and inter-regional transfers based on services offered.

Delegation/financial option
Under the delegated model of decentralization, the best strategy appears to combine national health insurance based on global budgets together with a targeting mechanism that establishes who is to receive a subsidy, and a clearly established subvention, possibly from public funding, for collaborative and supportive activities by NGOs. These strategies are best implemented by means of specific legal sanctions for the control of budgets by the decentralized authority, when the criteria for targeting specific clients are quite clear, and when accounting procedures are transparent. Existence of functional local government structures may be useful in most cases, and a strong Ministry of Health with powers to regulate and ensure quality is essential.
**Deconcentration/financial option**

The deconcentration model of decentralization does not have the capability or the authority for implementing independent financing policies. It however requires good policies and management by the Ministry of Health similar to those identified for the delegation model. In addition, community participation in setting priorities and in consultations on outcomes will increase the effectiveness and efficiency of the financing strategy established by the MOH.

**How to ensure that the link works effectively?**

The consensus is that developing policies aimed at improving the management of public health services is mainly the responsibility of the government. Other institutions in the private sector, in particular NGOs, are also involved in this process. The state should participate actively in enhancing equity in health care through four inter-related areas:

- **Steering role by Ministries of Health** in setting priorities that form the basis of policy agendas, including regulations, finance, and service delivery.

- **Regulation** by providing guidelines governing the implementation of decentralization activities and the mechanisms for protecting the poor.

- **Finance** by establishing the procedures for health expenditure and coverage involving decentralized units with provisions for fee waivers to the poor and adequate provider payment mechanisms.

- **Direct delivery of health services** by ensuring that the distribution of subsidies is targeted to the poor.
## Problems of Health Sector Reform and Reform Objectives

<table>
<thead>
<tr>
<th>Critical problems</th>
<th>Reform objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persistence of disparities in the health status of the population owing to factors such as poverty, education, family structure, and environmental factors.</td>
<td>Equity</td>
</tr>
<tr>
<td>Inequitable access to health services owing to income, knowledge, and location.</td>
<td></td>
</tr>
<tr>
<td>Universal coverage of services has not been attained owing to resources constraint, overriding short-term needs, and misallocation of resources.</td>
<td></td>
</tr>
<tr>
<td>Need to develop solidarity on financing of a socially agreed upon basic package of health care services.</td>
<td></td>
</tr>
<tr>
<td>Health care system is not responding adequately to current and emerging health needs of the population.</td>
<td></td>
</tr>
<tr>
<td>Weaknesses in the institutional capabilities for health care planning.</td>
<td></td>
</tr>
<tr>
<td>Need to place more emphasis on health promotion strategies.</td>
<td></td>
</tr>
<tr>
<td>Absence of quality assurance practices.</td>
<td></td>
</tr>
<tr>
<td>Lack of technology assessment programs.</td>
<td></td>
</tr>
<tr>
<td>Increasing litigation due to malpractice.</td>
<td></td>
</tr>
<tr>
<td>Patient dissatisfaction.</td>
<td></td>
</tr>
<tr>
<td>Inadequate strategic planning and management of the health care systems leading to misallocation of resources.</td>
<td></td>
</tr>
<tr>
<td>Wastage in the provision of health services.</td>
<td></td>
</tr>
<tr>
<td>Lack of maintenance of facilities and equipment.</td>
<td></td>
</tr>
<tr>
<td>Insufficient stock of drugs, supplies, and basic equipment in both ambulatory services and hospital care.</td>
<td></td>
</tr>
<tr>
<td>Persistent staff shortages for certain categories of health workers.</td>
<td></td>
</tr>
<tr>
<td>Low wages and low morale among health workers.</td>
<td></td>
</tr>
<tr>
<td>Overcrowded ambulatory and emergency departments in hospitals.</td>
<td></td>
</tr>
<tr>
<td>Insufficient complementarity between private and public provision of health services.</td>
<td></td>
</tr>
<tr>
<td>Need to develop analytic and programming capabilities.</td>
<td></td>
</tr>
<tr>
<td>Need to improve health care information systems.</td>
<td></td>
</tr>
<tr>
<td>Insufficient complementarity of public and private financing to achieve health goals and to sustain the provision of health services.</td>
<td></td>
</tr>
<tr>
<td>☐ Need to develop cost saving and containment mechanisms.</td>
<td></td>
</tr>
<tr>
<td>☐ Need to attain greater efficiency in the allocation of resources and value for money.</td>
<td></td>
</tr>
<tr>
<td>☐ Insufficient social participation in the organization and monitoring of health services provision.</td>
<td></td>
</tr>
<tr>
<td>☐ Need to expand the partnership for attaining health objectives.</td>
<td></td>
</tr>
<tr>
<td>☐ Need to establish linkages with other sectors for advancing effective intersectoral interventions that impact health.</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Caribbean Regional Health Study, CGCED, p. 149.
## Annex 2

### Basic Indicators of Attainment and Potential

<table>
<thead>
<tr>
<th>Countries</th>
<th>Adult literacy</th>
<th>Educational Enrolment</th>
<th>Life expectancy (years)</th>
<th>Human development Index</th>
<th>Unemployment %</th>
<th>Poverty Level %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbados</td>
<td>3</td>
<td>77</td>
<td>76</td>
<td>0.909</td>
<td>15.5</td>
<td>13.78</td>
</tr>
<tr>
<td>Antigua and Barbuda</td>
<td>5</td>
<td>76</td>
<td>75</td>
<td>0.895</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>The Bahamas</td>
<td>2</td>
<td>72</td>
<td>73</td>
<td>0.893</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Trinidad and Tobago</td>
<td>2</td>
<td>65</td>
<td>73</td>
<td>0.880</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>Dominica</td>
<td>6</td>
<td>77</td>
<td>73</td>
<td>0.879</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Grenada</td>
<td>2</td>
<td>78</td>
<td>72</td>
<td>0.851</td>
<td>18.8</td>
<td>24.6</td>
</tr>
<tr>
<td>St. Kitts &amp; Nevis</td>
<td>10</td>
<td>78</td>
<td>69</td>
<td>0.851</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>St. Vincent &amp; the Grenadines</td>
<td>18</td>
<td>78</td>
<td>72</td>
<td>0.845</td>
<td>--</td>
<td>23.2</td>
</tr>
<tr>
<td>St. Lucia</td>
<td>18</td>
<td>74</td>
<td>71</td>
<td>0.839</td>
<td>--</td>
<td>18.7</td>
</tr>
<tr>
<td>Belize</td>
<td>30</td>
<td>74</td>
<td>74</td>
<td>0.807</td>
<td>--</td>
<td>24.7</td>
</tr>
<tr>
<td>Suriname</td>
<td>7</td>
<td>71</td>
<td>71</td>
<td>0.796</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Jamaica</td>
<td>15</td>
<td>67</td>
<td>74</td>
<td>0.735</td>
<td>14.5</td>
<td>13.6</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>18</td>
<td>73</td>
<td>70</td>
<td>0.720</td>
<td>--</td>
<td>41</td>
</tr>
<tr>
<td>Guyana</td>
<td>2</td>
<td>64</td>
<td>63</td>
<td>0.670</td>
<td>11.1</td>
<td>35.2</td>
</tr>
<tr>
<td>Haiti</td>
<td>55</td>
<td>29</td>
<td>55</td>
<td>0.340</td>
<td>--</td>
<td>65</td>
</tr>
</tbody>
</table>

1. HDI is a composite of life expectancy, educational enrollment, adult literacy and income. The income component is in Annex 5. For consistency, the HDI and the three components in this table are taken from the UNDP, Human Development Report [1998].
2. Based on data from Downes [1999] and CDB Report [1998].
# Annex 3

## Poverty Alleviation Programs

<table>
<thead>
<tr>
<th>Country</th>
<th>Program/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbados</td>
<td>Ministry of Social Transformation with responsibility for development, childcare, and social welfare.</td>
</tr>
<tr>
<td></td>
<td>- Social Report on the Status of Households to provide profile of sectors to facilitate targeting based on actual needs, intersectoral collaboration and rationalization of resources to help vulnerable groups graduate out of welfare.</td>
</tr>
<tr>
<td></td>
<td>- Poverty Alleviation Bureau within Ministry has intersectoral representation to monitor the implementation of anti-poverty strategies.</td>
</tr>
<tr>
<td></td>
<td>- Social Investment Fund to assist in generating income and employment for small business ventures, especially in poor communities.</td>
</tr>
<tr>
<td>Guyana</td>
<td>Social Investment Amelioration Program (SIMAP) was designed to cushion the effects of the economic recovery program in the late 1980s–early 1990s on the most vulnerable groups.</td>
</tr>
<tr>
<td>Jamaica</td>
<td>National Poverty Eradication Program within the Office of the Prime Minister and its offshoot, the Jamaican Social Investment Fund emphasize community-based interventions undertaken in partnership with NGOs, the private sector and the communities.</td>
</tr>
<tr>
<td></td>
<td>- Target was established to decrease poverty by one-half in five years using SIFs, food stamps, and school feeding programs.</td>
</tr>
<tr>
<td></td>
<td>- Health care targeted to pregnant mothers and infants.</td>
</tr>
<tr>
<td></td>
<td>- Human Develop Program to develop new skill mixes.</td>
</tr>
<tr>
<td>Trinidad &amp; Tobago</td>
<td>Youth Training and Employment Partnership in existence over 15 years, is an illustration of a poverty alleviation strategy aimed at training for the workplace and generation of employment opportunities and various programs associated with community development.</td>
</tr>
<tr>
<td>Bahamas</td>
<td>Childcare, Education, and Health.</td>
</tr>
<tr>
<td></td>
<td>- Universal access to health programs.</td>
</tr>
<tr>
<td></td>
<td>- Universal access to education programs.</td>
</tr>
<tr>
<td>Suriname</td>
<td>Health Card system—main mechanism for access to care by poor.</td>
</tr>
<tr>
<td></td>
<td>- Ongoing efforts to make Health Sector Reform more poverty conscious, supported especially by UNICEF and the UNDP.</td>
</tr>
<tr>
<td>Belize</td>
<td>Commissioned a Poverty Assessment Report.</td>
</tr>
<tr>
<td>St. Vincent</td>
<td>No systematic efforts to alleviate poverty, but strategies include school feeding programs, youth skill development programs, and public assistance to vulnerable groups.</td>
</tr>
<tr>
<td>Grenada</td>
<td>Has also commissioned a health needs assessment and poverty situation analysis, which will focus especially on the informal economy, unemployment, and self-employment.</td>
</tr>
</tbody>
</table>

UNECLAC in collaboration with the CDB and UNDP initiated a regional dialogue and gained the commitment of all Caribbean governments to establish poverty reduction plans. UNDP was mandated to take the lead in the OECS countries. Poverty reduction plans have been formulated in several countries including St. Vincent, Grenada, and Dominica.
Annex 4

Access, Illness, and Utilization Patterns between the Poor and Non-Poor in the Caribbean

### Access:

- There was little difference in access to health care by the poor and non-poor in terms of treatment sought except in Belize and Guyana.
- Relative size of countries may play an important role if some groups are required to travel longer distances than others do to reach a health facility.
- Among the reasons for reporting an illness and not seeking care, twice as many of the poor compared with non-poor indicated it was due to lack of money.

### Reporting Illness:

- Poor women had a higher level of reported illness than did either poor or non-poor men.
- Non-poor women and men have higher levels of reported illness than do poor men.

### Utilization patterns:

- There was little difference between the poor and non-poor in the use of public hospitals.
- The poor made greater use of public health clinics.
- The non-poor (40%) made greater use of private health facilities than did the poor (26%).
- Poor men made greater use of public hospital (40%) in seeking medical attention than public health care facilities (35%) and private facilities (25%).
- Non-poor men made greater use of the private doctor (39%) than the public health care facilities (30%) and the public hospital (24%).
- Poor women made greater use of the public health center (55%) than the private doctor (25%) and the public hospital (20%).
- Non-poor women made more use of the facilities: public healthcare (39%), private doctor (31%), and public hospital (30%).
- Poor Children made greater use of the public health facilities (66%) than the private doctor (10%) and the public hospital (24%). In comparison, non-poor children (55%) visit private doctors, (15%) public health centers, and (30%) public hospitals.
- The non-poor over 65 years made greater use of the private doctor (55%) while more poor (66%) used the public health center.
- Only 18% of the population have health insurance but more than twice as many non-poor as poor are covered.
# Annex 5

## Basic Figures on Health Care Financing and Economic Activity

<table>
<thead>
<tr>
<th>Country</th>
<th>GDP per capita in US$ 1995</th>
<th>National Health Expenditure as % of GDP</th>
<th>Per capita National Health Expenditure</th>
<th>Public Financing (%)</th>
<th>Private Financing (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anguilla</td>
<td>6,584</td>
<td>5.1</td>
<td>336</td>
<td>53</td>
<td>47</td>
</tr>
<tr>
<td>Antigua and Barbuda</td>
<td>8,110</td>
<td>6.1</td>
<td>496</td>
<td>61</td>
<td>39</td>
</tr>
<tr>
<td>The Bahamas</td>
<td>11,940</td>
<td>4.3</td>
<td>518</td>
<td>58</td>
<td>42</td>
</tr>
<tr>
<td>Barbados</td>
<td>6,560</td>
<td>6.4</td>
<td>421</td>
<td>62</td>
<td>38</td>
</tr>
<tr>
<td>Belize</td>
<td>2,696</td>
<td>3.9</td>
<td>106</td>
<td>46</td>
<td>54</td>
</tr>
<tr>
<td>Dominica</td>
<td>2,990</td>
<td>6.6</td>
<td>198</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>Grenada</td>
<td>2,980</td>
<td>5.0</td>
<td>150</td>
<td>53</td>
<td>47</td>
</tr>
<tr>
<td>Guyana</td>
<td>590</td>
<td>7.5</td>
<td>44</td>
<td>69</td>
<td>31</td>
</tr>
<tr>
<td>Jamaica</td>
<td>1,510</td>
<td>5.0</td>
<td>76</td>
<td>49</td>
<td>51</td>
</tr>
<tr>
<td>Montserrat</td>
<td>5,893</td>
<td>6.5</td>
<td>383</td>
<td>63</td>
<td>37</td>
</tr>
<tr>
<td>St. Kitts and Nevis</td>
<td>5,170</td>
<td>5.6</td>
<td>289</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>St. Lucia</td>
<td>3,370</td>
<td>5.0</td>
<td>167</td>
<td>52</td>
<td>48</td>
</tr>
<tr>
<td>St. Vincent and the Grenadines</td>
<td>2,280</td>
<td>5.5</td>
<td>125</td>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>Suriname</td>
<td>1,118</td>
<td>8.0</td>
<td>95</td>
<td>75</td>
<td>25</td>
</tr>
<tr>
<td>Trinidad and Tobago</td>
<td>3,770</td>
<td>4.7</td>
<td>176</td>
<td>45</td>
<td>55</td>
</tr>
<tr>
<td>United States</td>
<td>26,980</td>
<td>14.3</td>
<td>3,835</td>
<td>44</td>
<td>56</td>
</tr>
<tr>
<td>Canada</td>
<td>19,380</td>
<td>9.8</td>
<td>1,899</td>
<td>71</td>
<td>29</td>
</tr>
<tr>
<td>LAC Region</td>
<td>3,289</td>
<td>7.3(*)</td>
<td>240(*)</td>
<td>41</td>
<td>59</td>
</tr>
</tbody>
</table>

(*) It does not include Canada or the United States.

**Source:** PAHO. *Health in the Americas*. 1998.
Annex 6

National Health Insurance and the Health of the Poor

Income-based Contributions

Identification and Enrollment of Poor

Lower of differential Co-payments

Universal NHI Plan

Public Financing

Improved Access and Utilization

Reliable source flows for Basic Package

Improved Availability and Quality of Services in Public and Private Sectors

Better Health and Health Security (Outcome)