

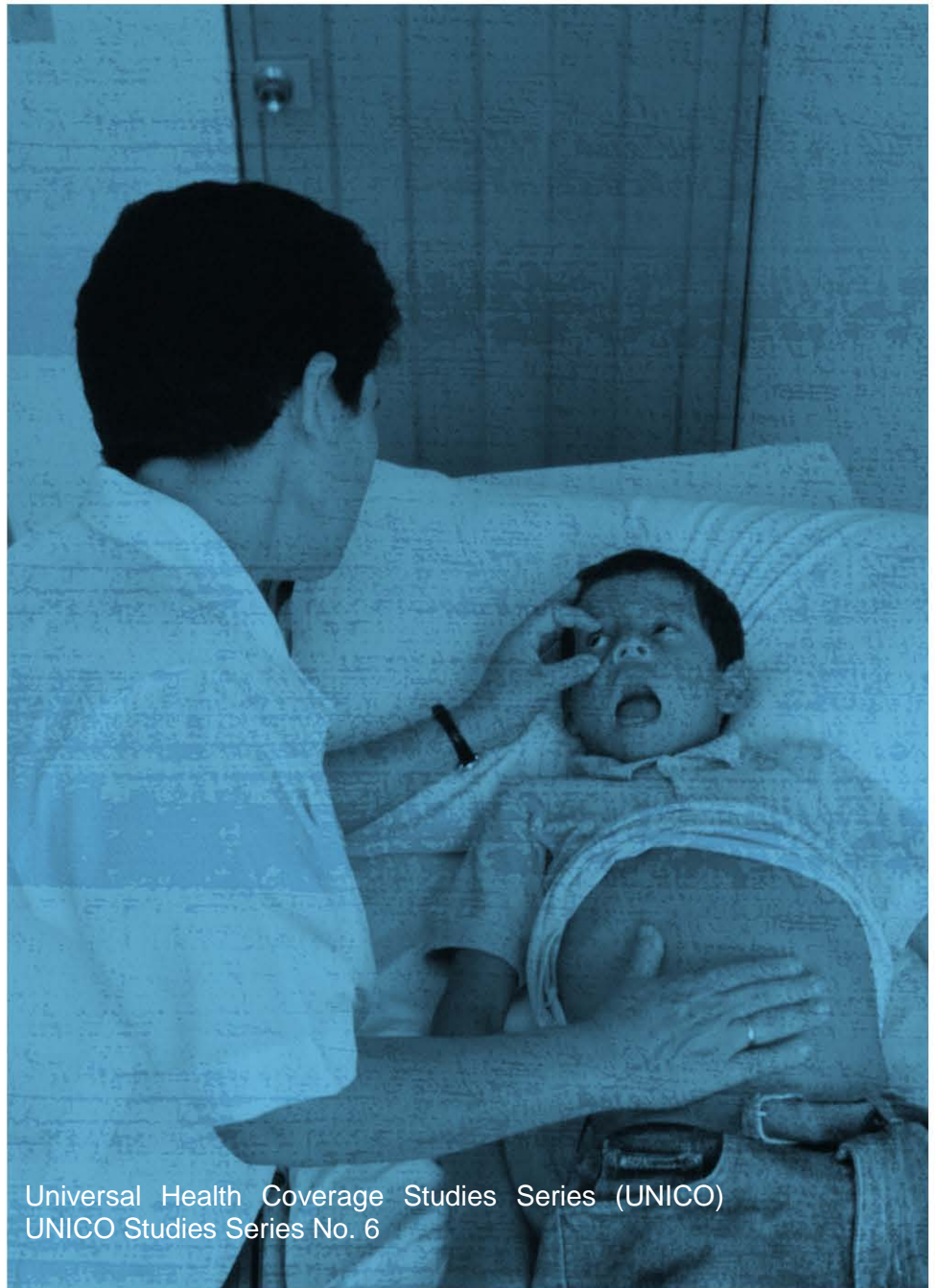


THE WORLD BANK

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# Jamaica's Effort in Improving Universal Access within Fiscal Constraints

Shiyan Chao



Human Development Network

Universal Health Coverage Studies Series (UNICO)  
UNICO Studies Series No. 6



# **UNICO Studies Series 6**

## **Jamaica's Effort in Improving Universal Access within Fiscal Constraints<sup>1</sup>**

Shiyan Chao

The World Bank, Washington DC, January 2013

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<sup>1</sup> This paper was prepared by Shiyan Chao (Senior Economist, Latin America and the Caribbean region). The author would like to thank Dr. Sheila Campbell-Forrester, Consultant, who assisted in the data collection, and Dr. Yuan Shi, for the analysis on abolition of user fees. The author is grateful to Messieurs Cecil White, Granville Gayle, and Aubrey Blaire, Vice Presidents of the National Health Fund, for providing useful information and comments. The author also benefited from the input from Dr. Kevin Harvey from the Ministry of Health in Jamaica. Critical review and comments were received at various stages of the preparation of this paper. The author is grateful to peer reviewers Antonio Giuffrida, Charles Griffin, Robert Janett, and Rekha Menon for their useful comments, and for comments received during the Authors' Workshop. The author wishes to particularly thank Daniel Cotlear (Task Team Leader for the UNICO Study) and Joana Godinho (Sector Manager) for their guidance and support.

## **The World Bank’s Universal Health Coverage Studies Series (UNICO)**

All people aspire to receive quality, affordable health care. In recent years, this aspiration has spurred calls for universal health coverage (UHC) and has given birth to a global UHC movement. In 2005, this movement led the World Health Assembly to call on governments to “develop their health systems, so that all people have access to services and do not suffer financial hardship paying for them.” In December 2012, the movement prompted the United Nations General Assembly to call on governments to “urgently and significantly scale-up efforts to accelerate the transition towards universal access to affordable and quality healthcare services.” Today, some 30 middle-income countries are implementing programs that aim to advance the transition to UHC, and many other low- and middle-income countries are considering launching similar programs.

The World Bank supports the efforts of countries to share prosperity by transitioning toward UHC with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, successful implementation requires that many instruments and institutions be in place. While different paths can be taken to expand coverage, all paths involve implementation challenges. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Study Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the *nuts and bolts* of programs that have expanded coverage from the bottom up—programs that have started with the poor and vulnerable rather than those initiated in a trickle-down fashion. The protocol consists of nine modules with over 300 questions that are designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following: (a) manage the benefits package, (b) manage processes to include the poor and vulnerable, (c) nudge efficiency reforms to the provision of care, (d) address new challenges in primary care, and (e) tweak financing mechanisms to align the incentives of different stakeholders in the health sector. To date, the *nuts and bolts* protocol has been used for two purposes: to create a database comparing programs implemented in different countries, and to produce case studies of programs in 24 developing countries and one high-income “comparator,” the state of Massachusetts in the United States. The protocol and case studies are being published as part of the UNICO Studies Series, and a comparative analysis will be available in 2013.

We trust that the protocol, case studies, and technical papers will provide UHC implementers with an expanded toolbox, make a contribution to discussions about UHC implementation, and that they will inform the UHC movement as it continues to expand worldwide.

Daniel Cotlear  
UNICO Studies Series Task Team Leader  
The World Bank  
Washington, DC

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## Abbreviations

GDP	gross domestic product
IDB	Inter-American Development Bank
IMF	International Monetary Fund
JADEP	Jamaica Drug for the Elderly Program
MDGS	Millennium Development Goals
MOH	Ministry of Health
NCDs	noncommunicable diseases
NGO	nongovernmental organizations
NHF	National Health Fund
NHIP	national health insurance plan
PAHO	Pan-American Health Organization
RHAs	Regional Health Authorities
WHO	World Health Organization

## **Executive Summary**

Jamaica's primary health care system was a model for the Caribbean region in the 1990s. Because of it, Jamaicans enjoy relatively better health status than people in other countries of similar income level in the Caribbean region. However, Jamaica's health system is being severely challenged by persistent and reemerging infectious diseases and by the rapid increase in noncommunicable diseases (NCDs) and injuries. At the same time, the country has suffered from low economic growth and carries a high debt burden, which leaves limited fiscal space for improving health care.

The Government of Jamaica has been trying to sustain the gain in health outcomes and improve access to health care for its population in an environment of constrained resources during the last decade. With the establishment of the Jamaica National Health Fund (NHF) in 2003 and the abolition of user fees at public facilities in 2008, the Government of Jamaica has taken steps toward achieving universal coverage.

This study reviews the achievements and challenges in expanding universal access in Jamaica and assesses the impact of the NHF's drug-subsidy programs and the abolition of user fees on universal access, and discusses policy options for achieving universal coverage.

The NHF was approved by statute in 2003 with the aim to "reduce the financial burden of health care on the public sector in Jamaica." Because NCDs had become the major causes of morbidity and mortality, the NHF aimed to introduce a public health management approach to their treatment, by providing individual and institutional health care benefits to Jamaicans. NHF Individual Benefits include subsidies on a range of prescribed pharmaceuticals for patients suffering from one of 15 specific chronic diseases. Beneficiaries are required to make a high copayment, ranging from 25 to 53 percent of the cost of the drugs.

Economic recession, high unemployment, and global health care cost escalation have made it increasingly difficult for households to afford health care. In April 2008, the government abolished user fees at public health facilities, and all Jamaicans have access to health care free of charge.

Based on the review carried out under this study, Jamaica's approach to universal coverage has produced mixed results. On the one hand, people have access to free care at public health facilities, and the NHF subsidizes drugs for people with NCDs and the elderly, so it seems that Jamaica is achieving universal access. On the other hand, the NHF covers only 19 percent of the total population, and with a relatively high copayment. The rich have benefited more from the NHF Individual Benefits.

Paradoxically, however, this move has had the effect of further widening the gap between the poor and the better-off population. Increased use of public health services has put a heavy burden on the public health system, which was already considered inefficient and lacking in human resources and with poor infrastructure and equipment. The implicit rationing is happening in the public health facilities where more people, including the poor, are increasingly using private health services. Due to increased use of the private sector, the NHF's drug subsidy program and the abolition of user fees have not brought down overall out-of-pocket health expenditures. In the end, the poor pay a higher proportion of their income for health care.

Thus, while in theory, Jamaica has reached universal access to health care, in practice, such coverage is incomplete and inadequate. The abolition of user fees did not guarantee universal access to care, particularly for the poor. Moving forward, the government needs to invest wisely in the health sector to reach real universal coverage.

The NHF can serve as an important building block for the ultimate goal of providing universal access to health care in Jamaica. For this reason, policy makers are expanding the role of the NHF. One option under discussion is to allocate to the NHF the government budget that has been earmarked to replace the income loss from user fees, and to use the NHF as a purchaser and financier for the most vulnerable population, while at the same time expanding the benefit package to offer a wider range of health services.



## **1. Study Objectives**

The Government of Jamaica has made important policy decisions in the last decade with the goal of achieving universal access to health care for its population. The approach to universal coverage that Jamaica took consists of two main policy interventions: the establishment of the Jamaica National Health Fund (NHF) in 2003 and the abolition of user fees at public facilities in 2008. The NHF provides a drug subsidy program targeting patients suffering from the 15 most common noncommunicable diseases (NCDs) and the elderly over 65. The abolition of user charges in public health facilities was intended to remove the financial barrier to access to health care. Jamaica's approach provides a unique situation for a case study on whether Jamaica has achieved universal health coverage.

This study reviews the achievements and challenges in expanding universal access to health care in Jamaica and assesses the impact of the NHF's drug subsidy program and the abolition of user fees on universal access to health care and discusses policy options toward achieving universal coverage.

## **2. Health Sector Overview**

Jamaica has made significant achievements in improving the population's health status. Life expectancy at birth increased from 38 years in 1900 to 73.1 in 2009, and the infant mortality rate fell from 174.3 per 1,000 live births to 14.6 during the same period.

Jamaica faces a double burden of disease: the continued challenge of communicable diseases coupled with the rise of NCDs. Communicable diseases were the greatest contributor to Jamaica's burden of disease in the 1960s and 1970s, but were surpassed by NCDs in the 1980s and 1990s. NCDs are currently the leading causes not only of mortality but also of morbidity, and their incidence and prevalence have increased in the last decade. Jamaica has made progress toward achieving three health-related Millennium Development Goals (MDGs): reducing child mortality, and combating HIV/AIDS, malaria, and other diseases; however, it is unlikely to meet the targets for these goals by 2015, particularly on maternal mortality. HIV/AIDS remains a serious threat and maternal mortality has increased (World Bank 2011). About 12 percent of children born in Jamaica in 2009 had low birth weight, among the highest in the region.<sup>2</sup> As in other countries of the region, obesity is a growing concern. Health outcome indicators are worse in rural areas and among the poorest quintiles.

### **Health System**

Jamaica's health system involves a mix of the public and private sectors. The public sector is the primary provider of public health and hospital services, while the private sector dominates ambulatory services and the provision of pharmaceuticals.

The public sector includes the Ministry of Health (MOH) and its agencies; four Regional Health Authorities (RHAs); and an extensive network of secondary and tertiary care facilities, consisting of 24 second level hospitals, including five specialist institutions and

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<sup>2</sup> UNICEF Internet Jamaica Statistics.

primary care facilities, comprising 322 primary health centers and four community hospitals, which are managed by the four RHAs. The public sector also includes the University Hospital of the West Indies and its Medical School and 10 dental and two family planning clinics (GOJ 2009). The combined bed capacity for public hospitals is 4,500 beds (Gordon-Strachan and Brenzel 2010). The MOH acquired the St. Joseph's Hospital in 2008, which operates as a public-private hospital. Funded by the government in partnership with the Government of Cuba, it has 44 beds and offers eye care services. This network ensures easy geographic access to basic health care services.

The functions of the MOH were decentralized in 1997 under the National Health Services Act. The Ministry is responsible for policy, planning, regulating, and purchasing functions, while the four RHAs are in charge of health service delivery. This reform aimed to increase the efficiency and responsiveness of the health sector to local needs. The RHAs provide health services through a nested system of health centers and hospitals. Pharmaceutical and diagnostic services are available at all hospitals and some health centers, and the National Public Health Laboratory serves as the national referral center. The RHAs are responsible for delivering health care services to all 14 parishes.

## **Private Sector**

The private sector is playing an important role in health care. Private health care is provided by general physicians and specialists, private laboratories and pharmacies, and a few hospitals. Nongovernmental organizations (NGOs) also provide ambulatory care, targeting the poorer segments of the population. The past decade has witnessed a growing private sector, particularly in the areas of ambulatory health services and pharmaceutical supplies. The private sector delivers 75 percent of all ambulatory care and 82 percent of all pharmaceutical purchases. The private sector owns nine small hospitals (25 percent of all hospitals in the country), although it provides less than 6 percent of total bed capacity (Gordon-Strachan and Brenzel 2010).

Providing primary health care is mainly the responsibility of the MOH. The number one national goal in the Vision 2030 Jamaica Strategy is "A Healthy and Stable Population." National strategies call for both better performance of the health care system and for making the population responsible for maintaining their own health.

Jamaica has had a well-established national surveillance system that consists of population-based surveys on NCDs and NCD risk factors and administrative databases; it is the only country in the Caribbean with consecutive national surveys on NCDs. These data have been used for policy and program development and for program evaluation. Funding is not specified by disease category, but targets are included in service agreements at the primary and secondary levels and for health promotion activities.

Jamaica's health system functions relatively well and its primary health care system has been a model for the Caribbean region. The World Health Organization (WHO) 2000 World Health Report ranked Jamaica eighth in the world in terms of health system efficiency, in that it has good health outcomes at relatively low costs. In the Pan-American Health Organization/WHO's (PAHO/WHO's) evaluation of performance of the essential public health functions in 2001 and 2011, Jamaica has made progress in eight of the 11

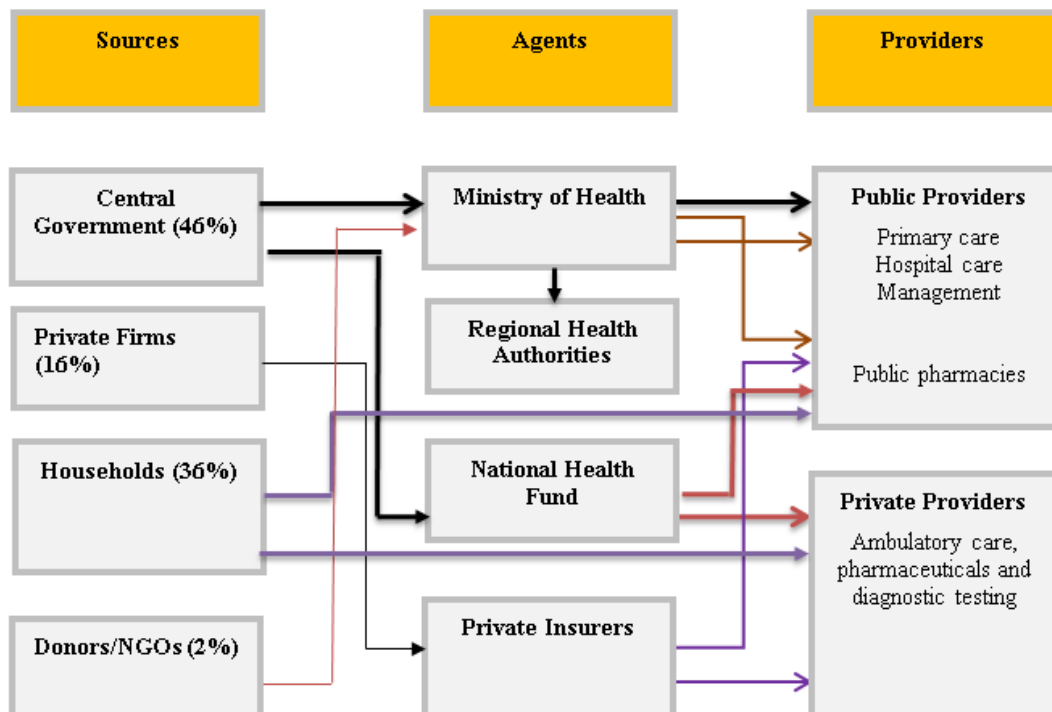
functions and had significant progress in human resources development and training in public health. However, it did not do as well as it did in 2001 in the areas of “monitoring, evaluation and analysis of health status”; “development of policies and institution capacity for public health planning and management”; and “strengthening of public health regulation and enforcement capacity” (PAHO 2012).

However, its health system is being severely challenged by persistent and reemerging infectious diseases, including dengue and HIV/AIDS, and by the rapid increase in NCDs and injuries. The aging of the population, technological advances, and increasing demand for health care have been driving up the costs of health care. At the same time, the country is experiencing limited economic growth and carrying heavy debts, thus limiting fiscal space. These factors are threatening the sustainability of the health system.

### 3. Health Care Financing

Financing for the health sector has been through a mix of public and private sources. The total health expenditure, as a percentage of GDP, has been between 4 and 6 percent in the last decade. Total health expenditure was about US\$680 million in 2009 (5.1 percent of GDP), equivalent to US\$228 per capita in 2009. The public sector accounted for 46 percent of total health expenditure, while private health insurance covered 16 percent, and out-of-pocket payments made up 36 percent (figure 1). International donors and NGOs covered only 2 percent of total health expenditure. The public sector largely financed hospital care, primary health care services, and regulatory functions. The private sector covers ambulatory care, pharmaceuticals, diagnostics, and overseas treatment (WHO 2011).

**Figure 1 Financing Flows in the Jamaican Health Sector, 2009**



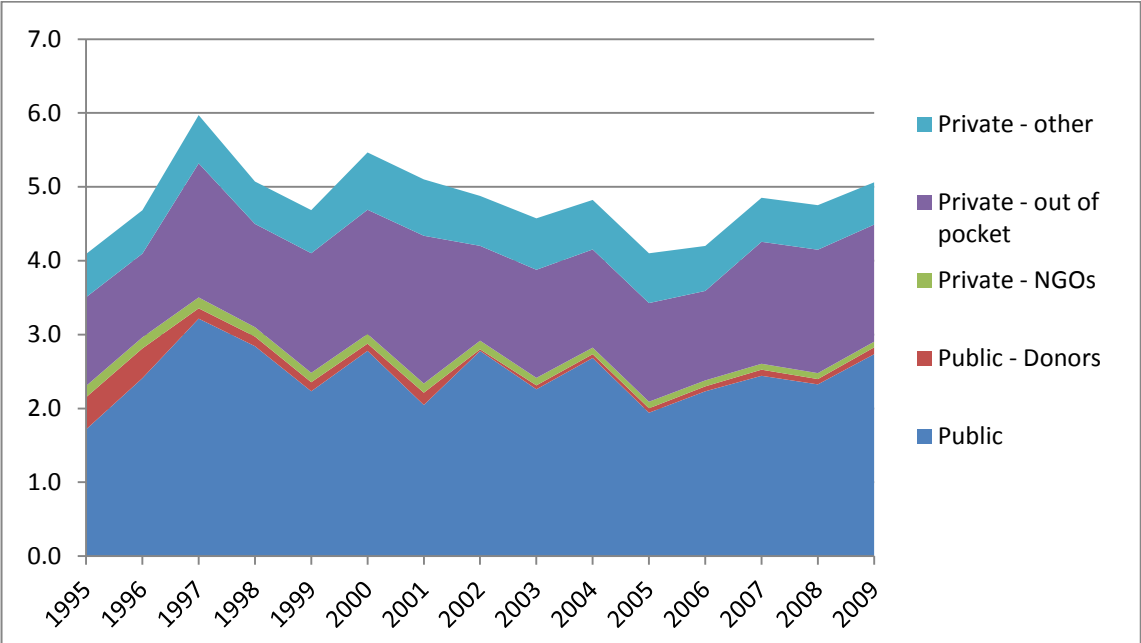
Public financing comes mainly from general taxation. The MOH receives its budget from the central government and transfers about 86 percent of its budget to RHAs for providing health care services. Spending by the MOH has ranged from less than 2 percent of GDP in the mid-1990s to 2.5 percent in the late 2000s.<sup>3</sup> The government also provides funding for the NHF to subsidize drugs for patients who suffer from NCDs and to invest in public health programs and health infrastructure. The funding sources for the NHF are from tobacco, payroll, and special consumption taxes (see details in section on NHF).

Less than 20 percent of the population was covered by private health insurance in 2009, mainly through employee health plans in medium and large establishments.

In 2008, the government abolished user fees at public health facilities to reduce financial barriers to accessing health. The government has increased its budget allocation to MOH to compensate for this income loss to health facilities. Since 2008, services in the public health centers and hospitals are free of charge at the point of service delivery. Households still pay for drugs at the public pharmacies.

There have been no major changes in sources of financing in the last decade. Figure 2 shows the overall trend of health financing from different sources. After the abolition of user fees in 2008/09, there were slight increases in both government and private spending on health.

**Figure 2 Jamaica: Health Expenditure by Source of Funding, 1995-2009 (Percent of GDP)**



Source: WHO 2011.

The most pressing concerns in the public health sector are the increasing demand for care and cost of services, compounded by the need for resources to meet these costs. The government is the main payer and provider of health services and faces many problems in financing the full range of primary, secondary, and tertiary health services.

<sup>3</sup> Information from Ministry of Health 2012.

The country's economic performance impacts the availability of resources for the health sector at the macro and micro levels. The Jamaican economy has experienced constant challenges since the 1970s, which were exacerbated by the 2008–09 global economic crisis. GDP growth was negative during 2008–10, and dropped to minus 3 percent in 2009. Heavy foreign borrowing has significantly increased its debt burden, which was estimated at 139.7 percent of GDP, which has been the most pressing development challenge for Jamaica. Jamaica had signed a 27-month Standby Arrangement with the International Monetary Fund (IMF) in February 2010, but the program went off track in late 2011. The country is hoping for a new IMF program, which could unlock budgetary support from development partners and financing from the international capital markets, which is currently unavailable to Jamaica.<sup>4</sup> At the same time, Jamaica's GDP per capita of 9,100 in purchasing power parity in 2011, as estimated by the IMF, defines it as an upper-middle-income country, thereby disqualifying it from some international aid, such as from the Global Fund. The supply of services has not been able to match the increasing demand. The demand and costs are driven up by demographic, epidemiological, technological, and social factors. Limited economic growth and lack of fiscal space has made it difficult to expand the coverage to meet increasing demand. Inadequate and, to some extent, inefficiently used, public sector resources have resulted in shortages of staff, supplies, and drugs, and a lack of maintenance of equipment and buildings.

#### **4. Expanding Universal Access within Fiscal Constraints**

##### **National Health Fund**

The government has recognized the critical importance of preventing and controlling NCDs. The Strategic Plan and the National Policy for the Promotion of Healthy Lifestyles were developed and implemented over a five-year period starting in 2004. The goal was to decrease the incidence of chronic diseases, high-risk sexual behavior, violence, and injury by the adaption of population behaviors to more appropriate ones—particularly of children, adolescents, and young adults.

Jamaica has a long history of searching for health financing methods to bridge the gap between budgetary allocations and increasing demand for care. The Inter-American Development Bank (IDB) conducted a study on the country's health financing innovations, from which the following summary of the development of national health insurance in Jamaica is derived (Barrett and Lalta 2004).

Discussions on some version of national health insurance were started in the 1960s when the National Insurance Scheme was established. Discussions and studies on establishing a national health insurance plan (NHIP) continued from the 1970s into the early 2000s, with support from international agencies (IDB and PAHO). However, the ideas never gathered enough political traction. Key issues that stalled the effort are related to the fundamental questions: Who should contribute? Who should manage the plan? What services should be in the benefit packages? Seventeen studies were conducted between 1982 and 1995 on the possibility of establishing national health insurance in Jamaica. Those studies culminated in

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<sup>4</sup> World Bank Jamaica Country website.

the preparation of a Green Paper<sup>5</sup> on the NHIP in 1997. The Green Paper outlined the NHIP goals, principles, and proposed operational features. The key features included universal coverage (“Health Security for All”); supplementing budgetary allocations to the health sector; and a benefit package covering prescription drugs, diagnostic services, and inpatient hospital care; choice of insurer and service provider; contribution through a levy on income; and the creation of a care fund for catastrophes.

The proposal to establish an NHIP faced opposition from the Ministry of Finance because of the difficult macroeconomic climate. It would cost the government a substantial amount to cover the premiums of the indigent population. The financial projections estimated that the NHIP would cost between J\$12 billion to J\$15 billion per year (US\$337 million to US\$421 million)—with about 50 percent to be provided by the government—while the annual MOH budget at that time was J\$6 billion (US\$169 million). The government revised the plan, which led to the design of the NHF, which took into consideration Jamaica’s macroeconomic and political context and funding limitations.

The NHF was established by the National Health Fund Act, approved by Parliament in 2003. The NHF adopted the mission, goals, and principles of the NHIP, as described in the Green Paper. The mission of the NHF is to “reduce the financial burden of health care on the public sector in Jamaica by providing funding and information to support improvements in health and to continually improve our processes to better serve our beneficiaries” (National Health Fund of Jamaica).<sup>6</sup>

The NHF is a statutory entity that receives and administers the funds collected. Because NCDs had become the major causes of morbidity and mortality, the NHF aimed to introduce a public health management approach to their treatment by providing individual and institutional health care benefits to Jamaicans.

The NHF is currently directed by a Board of Management composed of nine directors with the following six committees (the Chief Executive Officer an ex officio member of the Board of Management):

- The Medical Review Committee, which is responsible for monitoring adjustments to benefit levels, based on the severity of diagnoses, adjusting the benefits to be provided on the basis of changes in the use and/or availability of drugs, and making recommendations on the type of benefits and illnesses to be covered. The Medical Review Committee is responsible for monitoring and reviewing the Individual Benefits.
- The Operations Review Committee, which is responsible for overseeing the financial, supply chain, and administrative activities of the NHF.
- The Audit Committee, which is responsible for providing an independent reporting channel and ensuring that the recommendations of internal and external auditors have been implemented.

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<sup>5</sup> A Green Paper is a preliminary statement of proposed positions on a policy issue and is designed to foster public discussion and debate.

<sup>6</sup> Accessed at [www.nhf.org.jm](http://www.nhf.org.jm).

- The Procurement Committee, which is responsible for ensuring compliance with government procurement procedures.
- The Finance, Investment, and ICT<sup>7</sup> Committee, which is responsible for approving and reviewing investment activities and policy.
- The Human Resources Committee, which is responsible for the human resources management and administrative operations of the NHF.

The MOH oversees NHF operations, and the Chairmen of the Board of Management reports to the Minister of Health. The MOH is responsible for updating the National Formulary. The treatment regimen and the National Formulary were used to determine the pharmaceuticals required for proper treatment of specific NCDs.

The NHF functions and structure have been expanding. On April 1, 2011, the NHF assumed responsibility for the procurement, warehousing, and distribution of pharmaceuticals and medical sundries and for the operations of Drug Serv pharmacies.

## **Financing**

The NHF had three sources of revenue at inception: (a) the tax on the consumption of all tobacco products; (b) a payroll tax, which is collected in parallel with the National Insurance Scheme, which provides primarily for pensioner benefits; and (c) a special consumption tax, mainly from alcohol, petroleum, and motor vehicles. The tax collection mechanisms are mandatory contributions, and companies are required to make payments to meet their NHF obligations. The revenue mechanisms are reviewed and adjusted periodically to ensure the financial sustainability of the NHF.

Since the implementation of the NHF, other sources of revenue have been included, such as investment returns and interest on reserves. However, these are small compared with the three main sources.<sup>8</sup> The tobacco tax contributed the largest share (39 to 50 percent) up to 2006. After 2006, the major national tobacco producer (Carreras Limited) relocated to Trinidad and Tobago. The contribution from the tobacco tax thus declined to less than 25 percent during 2006–08. From 2006 to the present, payroll taxes have increasingly played a role in financing the NHF (figure 3). Overall, the NHF is financed by the following: 20 percent of taxation from tobacco-related products; 1 percent of the 5 percent payroll taxation of the National Insurance Scheme collected; and 5 percent of the Special Consumption Tax collected.<sup>9</sup> The NHF's total revenue from the three sources has increased from J\$2.6 billion in FY 2004 to J\$4.4 billion in FY12, an almost 70 percent increase in nominal terms in six years. However, it has had only a 2 percent increase in real terms.

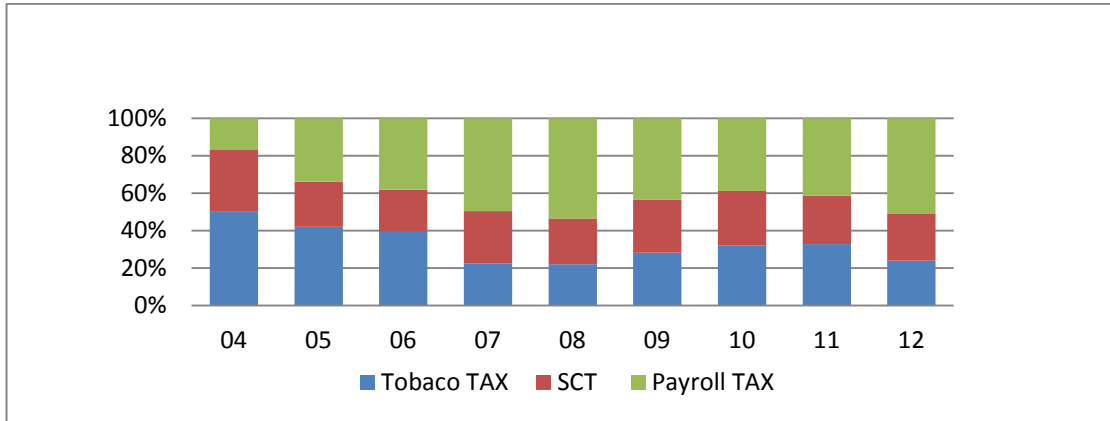
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<sup>7</sup> Information and Communications Technology.

<sup>8</sup> Based on the discussion with the NHF.

<sup>9</sup> Based on 2012 NHF data.

**Figure 3 Distribution of NHF Revenue by Source (%), Fiscal Years 2004-12**



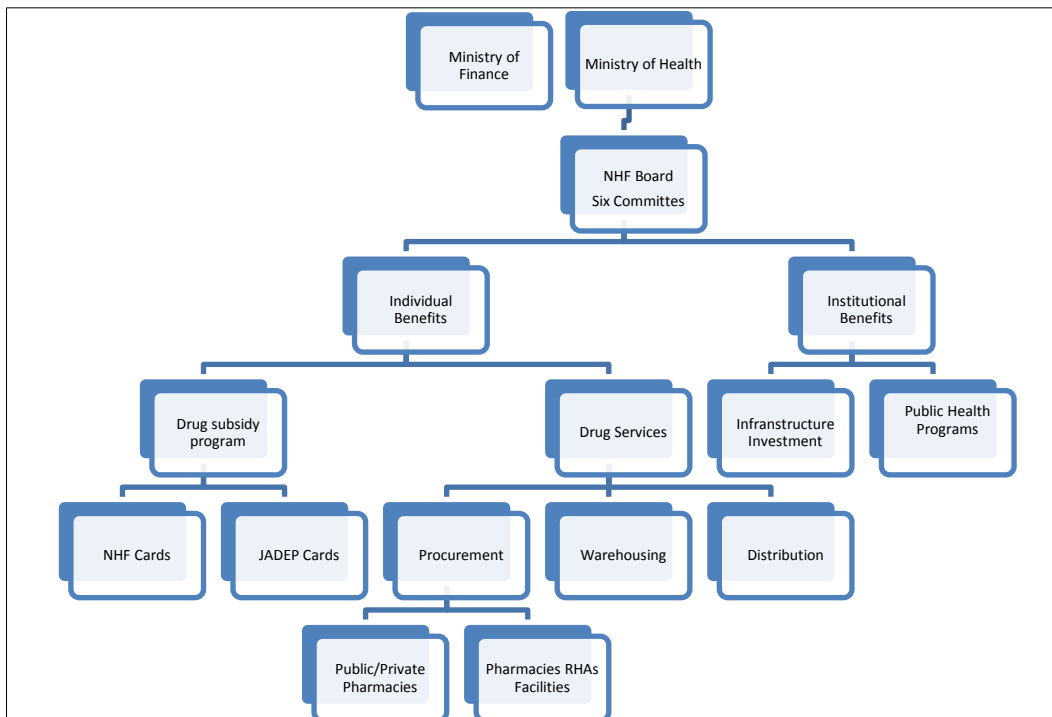
Source: National Health Fund 2012.  
 Note: SCT = special consumption tax.

### Governance

The National Health Fund Act established policies to protect the rights of beneficiaries, particularly regarding privacy, and the obligations of the NHF to its service providers, imposing penalties on beneficiaries and providers if found guilty of abusing their role in the system.

The framework that guides NHF operation is choice of provider by members, competition among service providers, and shared governance and responsibilities with key stakeholders. Figure 4 displays the NHF overall structure and programs.

**Figure 4 Organization Structure of the NHF**



Source: Based on the information from the NHF 2012.



## **5. Targeting, Identification, and Enrolment of Beneficiaries**

### **Institutional Benefits**

The NHF provides Institutional Benefits in the form of grants to two subfunds—the Health Promotion Fund and the Health Support Fund. The Health Promotion Fund finances public and private sector health promotion and disease prevention programs, and takes up at least 10 percent of NHF revenues. The Health Support Fund assists public agencies by financing infrastructure development, such as the purchase of equipment and the refurbishment and construction of health facilities. The operations of the Health Support Fund take up at least 15 percent of annual NHF revenues. Institutions must submit project proposals to the NHF for funding from the Institutional Benefits, and the proposals are evaluated by an NHF committee using the national health care priorities defined by the government.

### **Individual Benefits**

The NHF responded to the need for the public sector to help individuals address their NCDs. The macroeconomic recession at the beginning of this decade caused high unemployment and escalated health care costs. This made it increasingly difficult for households with family members that have multiple chronic conditions to afford the high cost of drugs needed to treat and control them. More than half of total health expenditure went to private health services. Of this, 83 percent was out-of-pocket expenditure, mainly for pharmaceuticals (World Health Organization 2009).

One of the major functions of the NHF is to provide an Individual Benefit Package, and more than 50 percent of the NHF budget since its establishment has been allocated for Individual Benefits. NHF Individual Benefits include subsidies toward a range of prescribed pharmaceuticals for patients with specific chronic diseases.

### **Eligibility**

All residents of Jamaica (except tourists, in-transit passengers, and temporary workers with a work permit for less than one year) suffering from NCDs are eligible to enroll in the Jamaica Drug for the Elderly Program (JADEP) and/or the NHF Card Program. Beneficiaries over 60 years of age enroll in the JADEP, while the NHF Card Program subsidizes drugs for people of all ages. The JADEP was launched in 1996 by the MOH as a national social assistance program to cover Jamaicans at least 60 years of age and diagnosed with one or more chronic diseases. The NHF took over the JADEP from the MOH. Beneficiaries of the NHF Card Program are automatically enrolled in the JADEP at the age of 60. Those among the eligible population need to apply to be enrolled in the NHF or JADEP.

## **Benefit Packages**

The NHF Individual Benefit package is a drug subsidy program that covers 15 chronic illnesses: arthritis, asthma, benign prostatic hyperplasia or enlarged prostate, diabetes, ischemic heart disease, breast cancer, epilepsy, high cholesterol, major depression, rheumatic heart disease, glaucoma, prostate cancer, psychosis, vascular disease, and hypertension. NHF Individual Benefits cover only drugs prescribed by a registered practitioner or dispensed by authorized providers. The Medical Review Committee of the NHF Board periodically reviews the NHF Individual Benefits to include or exclude specific drugs.

NHF subsidies are set at a fixed dollar value and are based on a reference pricing mechanism. The reference price is determined from the lowest available price of the active pharmaceutical ingredient. The subsidy is then set at 80 percent of the reference price. The current subsidy ranges between 47 percent to 75 percent of the retail prices of the drugs.<sup>10</sup>

## **Copayments**

Copayments under the NHF are relatively high. The NHF provides a subsidy toward the cost of the list of agreed drugs, based on the best market prices. Beneficiaries are required to make a copayment toward the cost of their drugs. The copayment for drugs has ranged from 25 to 53 percent.

## **Provider Participation**

The NHF provides policy guidelines for providers participating in the NHF Individual program. To be eligible to participate in the NHF Individual program, providers need to meet the appropriate professional and medical standards required for accreditation by the NHF. Providers are not allowed to refuse services to NHF beneficiaries. The NHF providers are paid subsidies based on the price for the agreed drugs set by the NHF, and the remainder of the costs is covered either by commercial health insurance or out-of-pocket payments. Providers are required to prepare complete and accurate claims for the NHF payment, and to maintain adequate records, which are subject to audit by the NHF. All providers submit electronic claims and are reimbursed electronically within 10 working days of providing the service.

## **Enrolment**

All patients seeking to obtain NHF Individual Benefits are required to enroll with the NHF. People need to present verification of their illness by a registered medical practitioner, and receive an NHF card. NHF beneficiaries are registered using their Tax Registration Number, which is a unique identifier.

Eligible beneficiaries can enroll in the NHF at any government health center, the national council for senior citizens, or the NHF head office or its branches by providing the national

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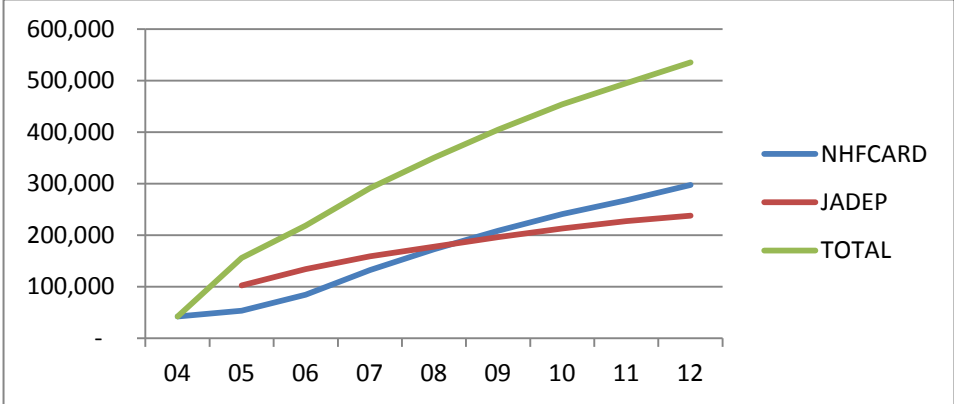
<sup>10</sup> Information provided by the NHF in December 2012.

identification card and documents certifying their age. Application documents for both JADEP and NHF enrolment are available online through the NHF website. Personal appearance for enrolment in the JADEP is not required for seniors who submit the required documentation through an entrusted person.

At its initiation, the NHF organized active outreach and public information programs to reach the eligible population. Awareness of the NHF Card and the JADEP among Jamaicans is high. The Jamaica Health and Lifestyle Survey, conducted in 2007 to 2008 among 2,848 respondents aged 15 to 74, identified that 77 percent of the population (74 percent of men and 80 percent of women) had heard of the NHF Card program and 9.5 percent (7.1 percent of men and 11.9 percent of women) were enrolled in the NHF Card program. A higher proportion of women across all age categories have heard of the NHF Card, and while the proportion of men who have heard of the fund did not vary significantly with age, older women were more aware of the services than younger women (World Bank 2011).

Since inception, NHF and JADEP enrolment has increased considerably over time. According to NHF administrative data, enrolments for the NHF increased from 42,147 in March 2004 to 297,336 in March 2012—a sevenfold increase in seven years (figure 5). JADEP participants increased from 102,552 in March 2005 to 237,919 in March 2012, resulting in a total of 535,255 program beneficiaries by March 2012, or about 19 percent of the Jamaican population.

**Figure 5 NHF Card and JADEP Enrolment, FY 2004–12**



Source: The information provided by NHF2012.

**6. Management of Public Funds in the NHF**

**Allocation between Institutional and Individual Benefits**

The creation of the NHF in 2003 gave the government an additional instrument for pooling funds for financing and purchasing health services. On the supply side, the NHF Institutional Benefits program finances capital investment in the health sector, such as renovating and building health facilities and providing equipment. Proposals submitted to the NHF are reviewed and approved by an Institutional Subcommittee of the NHF Board. The Grant Agreement for an approved project is signed by the NHF and the implementing

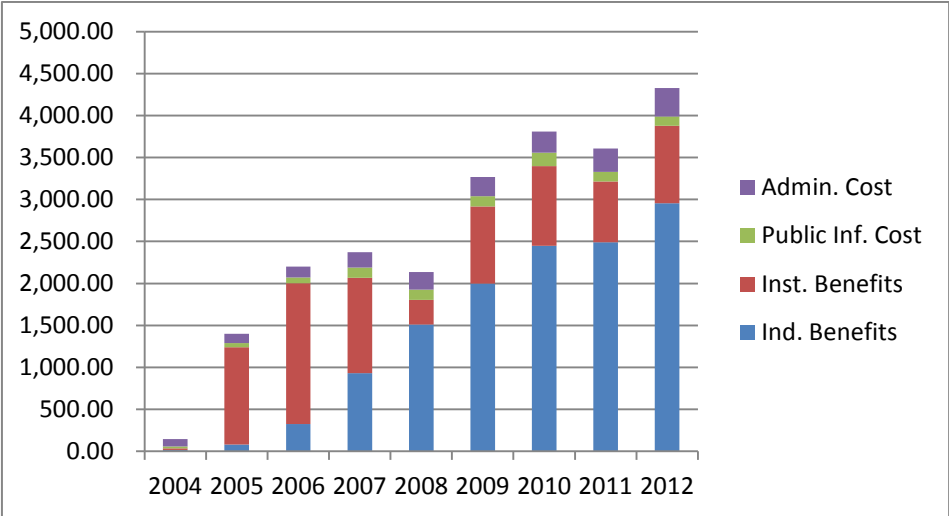
entity. This is one of the main ways that capital investment in health facilities at the regional and lower levels is funded.

In addition to the investment program for health infrastructure, the NHF Institutional Benefits also finance public health activities, such as health promotion activities and health sector research programs. For example, the NHF funded the Jamaica Healthy Lifestyle Surveys, which have provided information and evidence useful for policy and program development. The Institution Benefits programs have maintained a similar level of funding after a significant drop in 2008, when Jamaica experienced a major blow from the global economic crisis. However, Institutional Benefits accounted for only 20 percent of NHF revenue in 2011.

The NHF is also one of the major sources for financing treatment and care on the demand side, through individual NHF benefits. The majority of the funding under the NHF from 2004 to 2012 was allocated to Individual Benefits, and the proportion of funding spent on Individual Benefits is likely to continue to increase given the expansion of membership and increased demand for drug subsidy payments. In 2004, at the inception of the NHF, only 10 percent of total revenue was spent on Individual Benefits. This share increased to about 70 percent in 2011.

The Individual Benefits is the NHF’s priority. It is a challenge to decide how the NHF should best use the resources available, and how to allocate the funds between its two programs to best achieve its mission. In the earlier years, Individual Benefits spending was relatively low and more funds were spent on Institutional Benefits. Current practice treats spending on Institutional Benefits as discretionary, and it is based on funds available after the Individual Benefits have been met (figure 6).

**Figure 6 NHF Expenditure Distribution, 2004–12 (in J\$'000)**



Source: The National Health Fund 2012.

From the point of view of long-term development, the NHF should increase financing of its institutional programs—that is, more funding for prevention and capacity building as opposed to financing of its individual programs, which focus on treatment. However, the reality is that funding for the NHF individual programs is more likely to rise because of

increased demand for treatment. If total revenue is not increasing, then the individual programs will likely absorb a larger share of the budget, and the institutional program may suffer. The Ministry of Finance is aware of this and has promised to increase financing, using the newly introduced gas tax and setting a new threshold for the National Insurance Scheme. However, the primary mitigation measure when facing a serious financial difficulty would be to reduce the number of institutional projects financed, not the numbers enrolled (*The Gleaner* 2009).

### Management of the Benefit Package

Benefit coverage of the NHF has been increasing. NHF beneficiaries were eligible, initially, to purchase 182 drugs at a subsidized price at 200 Provider Pharmacies across the country. By the 2009 fiscal year, the total number of items on the NHF drug list had reached 1,288, and the total number of Provider Pharmacies had increased to 422. A total of 2.6 million claims were submitted in 2011, with a total value of J\$4.65 billion, and the NHF paid J\$2.56 billion, equivalent to a 55 percent subsidy (table 1).

**Table 1 NHF Claims and Subsidy Rates, 2003–12**

Year	Number of People Claiming	Total Claims	Number of Claims per Member	Total Cost of Claims Submitted (in J\$, 2012 prices)	Total Subsidy Paid (in J\$, 2012 prices)	% Subsidy
2003 <sup>a</sup>	3,433	8,222	2.4	J\$1,821,275	4,464,001	34
2004	13,085	62,980	4.8	J\$15,762,997	34,298,481	39
2005	30,887	258,096	8.4	J\$108,217,168	221,398,809	48
2006	69,890	779,173	11.1	J\$491,260,150	1,056,102,039	60
2007	104,547	1,453,607	14	J\$1,128,487,380	1,990,690,617	59
2008	126,962	1,829,611	14.4	J\$1,970,177,014	2,269,245,367	57
2009	145,018	2,124,880	14.6	J\$3,014,326,009	2,574,921,851	51
2010	156,910	2,324,455	14.8	J\$3,730,397,417	2,443,450,853	49
2011	171,313	2,643,439	15.4	J\$4,335,145,099	2,742,259,393	55
2012 <sup>b</sup>	138,719	742,561	5.3	J\$1,273,691,062	733,694,048	58

Source: National Health Fund 2012.

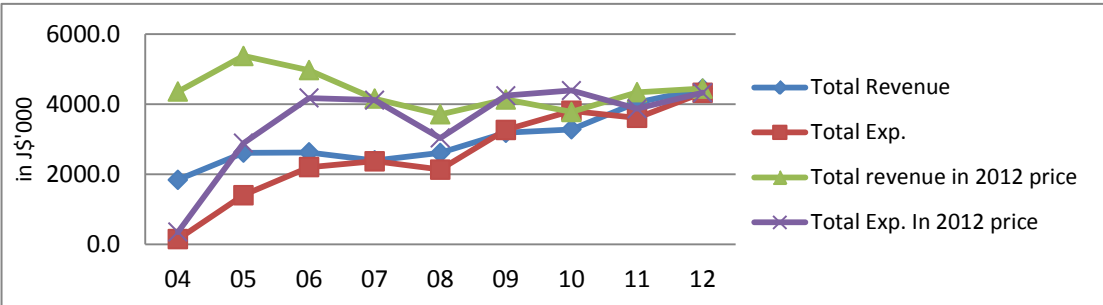
a. Data for August to December 2003.

b. Data for January to March 2012.

The total number of prescriptions claimed reached J\$2.6 million, with an average of J\$15.3 claims per member—a more than fivefold increase since NHF inception in 2003. While the number of eligible drugs for NHF financing and the number of claims has increased significantly, the reimbursement rate by the NHF did not necessarily increase. In 2010, the average portion subsidized was reduced to below 50 percent. Clearly, to avoid a deficit, the NHF reduced its subsidies and the financial risks were borne by consumers.

The NHF has successfully managed its benefit package within its resource envelope. Overall, the NHF has maintained its financial sustainability by keeping expenditure within its revenue (figure 7). The NHF has been closely monitoring the claims and adjusted the reimbursement rates to avoid an overrun of its annual budget for Individual Benefits. The subsidy is set at a fixed amount per item, based on reference pricing. Managing the benefit package became a tool for cost control and cost sharing to deal with the increasing expenditure on drugs. The NHF provides the benefits based on the revenue it receives and does not bear any risk of an overrun. This approach allows the NHF to be financially viable. However, it offers less financial protection for NCD patients and their families. The financial risk pooling under the NHF is still limited.

**Figure 7 NHF Revenue and Expenditure Distribution, 2004–12 (in J\$'000)**



Source: National Health Fund 2012.

**Assessing Impact of the Individual Benefits**

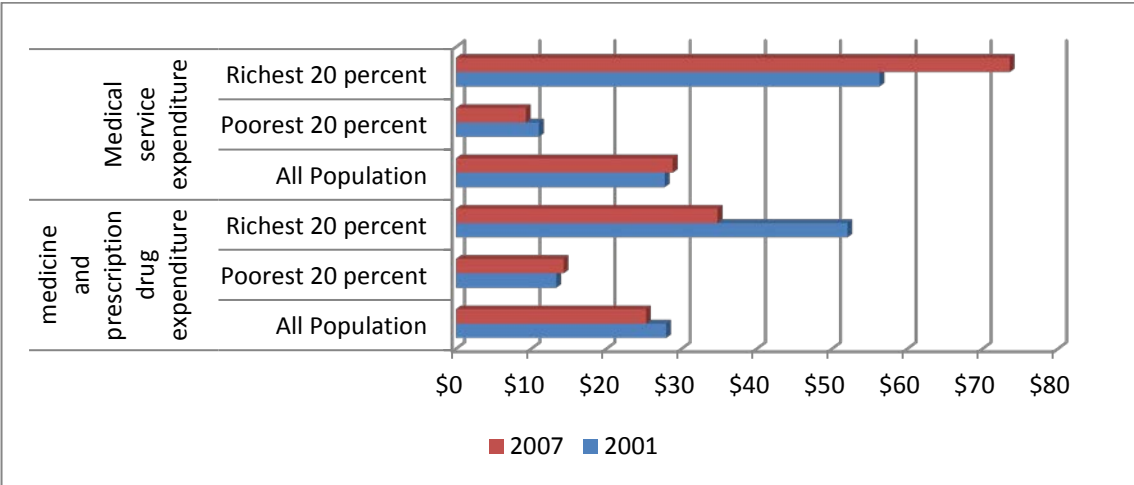
The NHF has achieved its primary goal of making NCD drugs more affordable. The World Bank conducted a study to assess the initial impact of the NHF drug subsidy program in reducing out-of-pocket spending on health care by NCD patients and in utilizing health care, comparing NCD patients with non-NCD patients. The results from the study indicate that NCD patients under the NHF paid less out-of-pocket for their pharmaceuticals than NCD patients without NHF coverage (World Bank 2011). Thus, the NHF improved access to care for NCD patients. People with NHF cards in general spent less on pharmaceuticals but more on medical services because medical expenditures are not covered by the NHF. The total medical expenditure for NCDs did not show a reduction after the introduction of the NHF, because the savings on pharmaceuticals were spent on additional medical consultations.

The NHF increased access to secondary prevention of NCDs—that is, to health care to stop or slow diseases from progressing to advanced stages—by making the treatment of major NCDs more affordable, in part by removing, to a certain degree, financial barriers to access such treatment. Even though data on the status of illness for NCD patients before and after the NHF are not available, based on international evidence on using pharmaceutical treatment as secondary prevention, it can be expected that the NHF could play a role in secondary prevention of NCDs in Jamaica.

The NHF Reference Pricing policy would have an impact on the pharmaceutical market in Jamaica. The reference price the NHF used is based on the lowest available price of the active pharmaceutical ingredient, and the subsidy is then set at 80 percent of the reference price. This method encourages pharmacies to use generic drugs and puts pressure on the pharmaceutical market for lower prices. However, due to lack of data, this paper cannot provide an in-depth analysis on the impact of the NHF’s drug subsidy program on pharmaceutical prices in Jamaica.

Distribution of NHF benefits is unequal among socioeconomic groups. The NHF focus is on people with NCDs and people in old age, and does not target the poor specifically. The rich benefited more from the government subsidy of pharmaceuticals, and they spent 36 percent less on drugs in 2007 than they did in 2000, before the establishment of the NHF. They are also more likely to join the NHF and JADEP. The expenditure on prescription drugs among the poorest quintile has increased slightly (figure 8).

**Figure 8 Individual Annual Medical Expenditures before and after the NHF among the NCD Population (in J\$1,000 at constant 2008 values)**



Sources: World Bank 2011.  
 Note: a. Two-year expenditure data were combined and annualized for 2000 and 2001 before the NHF, and 2006 and 2007 after the NHF, in order to expand the study sample size.

Overall, with respect to the goal of improving universal access to care, the NHF did succeed in achieving improved utilization and reduced out-of-pocket spending for NCD patients. However, the NHF failed to target the poor, who needed the drug subsidy the most. The rich benefit more from the government’s subsidy programs; thus, there is increased inequality in access to care.

**7. Information Environment**

The NHF receives claims from providers only, not from beneficiaries, thus it requires providers to keep proper records. Service providers are reimbursed an agreed amount for each benefit item on a fee-for-service basis.

The NHF information system records its members' personal information, health status, and use of NHF services. Processing transactions between the provider and the NHF is computerized online and in real time—the provider connects the transaction via the Internet or a telephone line. The NHF adjudicates the claim immediately after validating the provider, the beneficiary, the NHF card, the benefit item, and claim frequency. Once the system accepts the claim, the NHF pays the provider. The manual submission of claims is allowed, but providers have incentives to use the computerized system to avoid delays in the adjudication process and in the receipt of payment. This system validates and records provider, beneficiary, and utilization information.

Claims data are transferred to the NHF data provider and beneficiary databases. The NHF has information on the use of the benefit by each member, and on each prescription filled by each registered provider. Such data are used to monitor utilization and to set reimbursement rates for drugs.

The NHF information system is not linked to other information systems in the health sector or the National Insurance Scheme. The degree of fragmentation in information management and the lack of human resources capacity in the NHF have hampered the use of the data collected for policy analyses. For example, the NHF information system can monitor the behavior of doctors in prescribing drugs. Such data could provide a powerful tool for promoting rational drugs use and improve efficiency in using prescription drugs, but the NHF has yet to use this tool fully.

## **8. The Goal of Universal Access and the Abolition of User Fees**

Achieving universal health care coverage (“Health Security for All”) has been a long-term goal for Jamaica. In a context of limited fiscal space and financial resources, the government has been struggling to find ways to secure financing for health and provide universal access to health care. Out-of-pocket spending has been a major source of health financing in Jamaica. Early in this decade, more than half of the total health expenditures were for private health services and 83 percent of that spending was out-of-pocket (WHO 2009). User fees contributed 10.2 percent of the revenue of RHAs in 2006/07.

Jamaica's economy has been affected by the global economic crisis. The GDP growth rate started falling from a high of 2.7 percent in 2006 to minus 2.8 percent in 2009. Unemployment rates have increased. The debt-to-GDP ratio was 132 percent in 2009. Economic recession, high unemployment, and the global escalation of health care costs have made it increasingly difficult for households to afford health care. User fees were considered a “major impediment” for poor people in accessing health care. In April 2008, the government abolished user fees at public health facilities, and all people have access to health care free of charge. A provision of \$J1 billion was made in the 2008/09 budget, partially to compensate for lost revenue of \$J1.7 billion from user fees (Jamaica Government n.d.).

This policy change had significant impact on access to and utilization of health care. To assess the impact of the abolition of user fees on access to and utilization of health care, the World Bank carried out a comparative analysis of the situation before and after the policy change, using the 2007, 2008, and 2009 Jamaica Survey of Living Conditions.<sup>11</sup> The results

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<sup>11</sup> A policy analysis conducted by Yuyan Shi, consultant to the World Bank (2011).

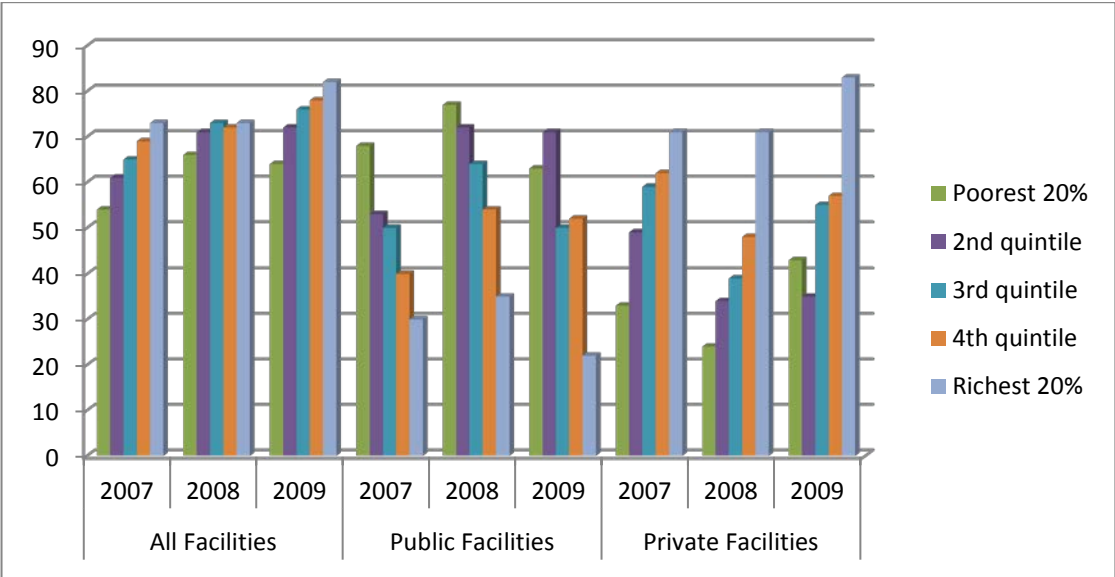


of this analysis indicate that both the poor and rich have benefited from the removal of user fees, and utilization of health care has substantially increased.

Visits to health care services increased by roughly 5 percent each year from 2007 to 2009. This policy was initially considered a success in improving access to universal coverage.

All population quintiles have benefited from the abolition of user fees, particularly the poor in 2008. The utilization of health facilities has increased compared to before the abolition of user fees for all the population, particularly for the poor immediately after the fee removal. The poorest population shows a 10 percent increase in health care facility visits, and the richest a 9 percent increase. An analysis of the initial impact has shown that abolishing user fees at public health facilities has further widened the gaps between the poor and the better-off population in using services from public compared to private health facilities<sup>12</sup> (figure 9).

**Figure 9 Health Care Service Visits by Population Quintile and Facility Type (in %)**



Source: Analysis of Jamaica Surveys of Living Conditions 2007–2009.

The richest quintile visited private facilities for care more frequently than before (these facilities accounted for 83 percent of their visits in 2009, up from 71 percent in 2007), while the lowest two quintiles were more likely to choose public facilities. The majority of the poor used public facilities in 2009. However, increased use of public health services put a heavy burden on the public health system, which was already considered inefficient and lacking in human resources and with poor infrastructure and equipment. Complaints are on the rise regarding long waiting times, insufficient supplies, and the poor quality of services in public facilities.<sup>13</sup> The data from 2009 showed an increasing trend of using private health facilities even among the poorest quintile. The evidence clearly indicates that abolishing user fees has further driven the rich to use private health providers. The distribution of

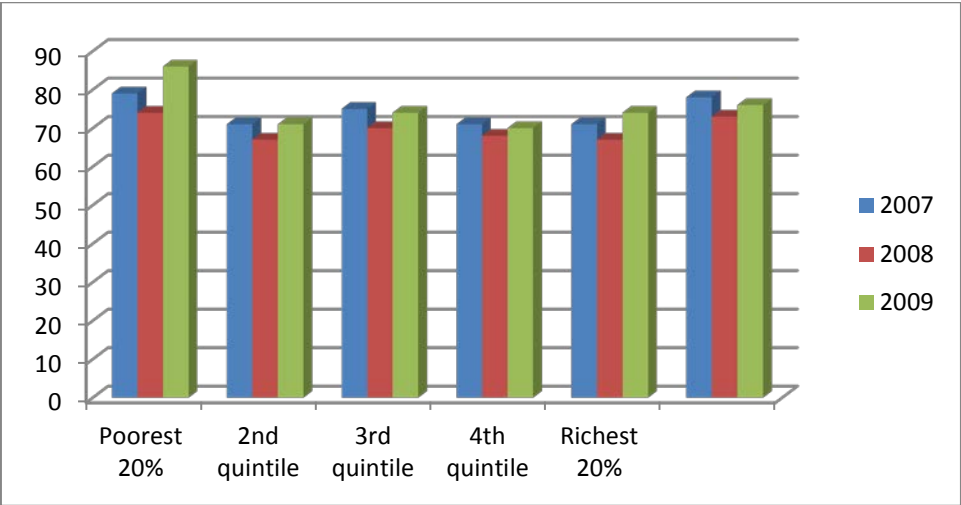
<sup>12</sup> More recent household data were not available for this analysis.

<sup>13</sup> Based on field visits to health facilities and discussions with health workers.

health spending and access to health services is uneven among the population and across geographic areas. Jamaica’s experience in the abolition of user fees is not unique. Uganda reported a similar experience when it abolished user fees in public health facilities. Abolition of user fees improved access to health services but did not achieve financial protection. Out-of-pocket expenditure remains high and mainly affects the poor, and a dual system emerges where the wealthier population is switching to the private sector (Orem et al. 2011).

Analysis of the Jamaica Survey of Living Conditions data also reveals that doing away with the user fees did not have much impact on the use of prescription drugs or the NHF Individual Benefits program. The pattern in prescription drug purchases was relatively stable before and after the abolition of user fees. There was a slight decrease in the percentage of patients that procured pharmaceuticals in 2008, and the level returned to that of before the user fee removal in 2009 (figure 10). About 73 percent of the population reporting ill purchased drugs in 2007, as in 2009, but there was a slight reduction in 2008 (69 percent). The majority of patients purchased drugs from private facilities, which account for roughly 80 percent of total purchases—ranging from 64 percent for the poorest quintile to 96 percent for the richest quintile in 2009. Health spending increases proportionally with greater income, and the data reported by STATIN and PIOJ (2010) also suggest an urban/rural divide. Access to health insurance is higher among the richest quintile than the poorest (20.8 percent compared to 13.6 percent).

**Figure 10 Percentage of Population who Reported Ill and who Procured Drugs by Quintile, 2007–09**



Source: Analysis of Jamaica Surveys of Living Conditions 2007–2009.

More people are using private health services. PAHO’s 2012 report pointed out that the abolition of user fees led to greater use of the services. However, it became difficult to meet the growing demand and funding fell short, despite the subsidies provided to compensate for the loss of the revenue. People at every income level increasingly sought private medical care (PAHO 2012).

One of the current policy debates is related to whether the abolition of user fees, with the increasing budget allocation to the public sector, has achieved the ultimate goal of improving universal access to health care. Some argue that those who now have access to health care due to the removal of user fees would be no better off if quality of care is lacking because of insufficient supplies or personnel, resulting in poorer quality of care. The MOH is considering whether to reinstate user fees, so that the better-off population groups, which can afford to pay, contribute to revenue for health facilities to improve the quality of care. However, there are concerns that user fees would detract from the country's efforts to achieve universal access to care. The next section considers some policy options.<sup>14</sup>

## **9. Pending Agenda**

In theory, Jamaica has achieved universal access to health care. In practice, such coverage is incomplete and inadequate. The abolition of user fees did not guarantee universal access to care, particularly for the poor. Subsidizing the loss of revenue from user fees could be difficult to sustain. The government clearly needs to explore other options to advance universal coverage. The following are some options that the government might consider.

### **Expanding the Role of the NHF**

The NHF has been operational for eight years and is at a crossroad regarding its future role and functions. The macroeconomic and fiscal constraints present the NHF with more challenges than ever before. However, past operational experience and newly available information may help policy makers make smarter decisions on the next phase of NHF development. Specific issues that have arisen are discussed here.

#### **NHF as Health Service Financier**

The NHF has been a successful health financing instrument, generating a steady income for health services. The NHF not only subsidizes prescription drugs for NCD patients, but also provides funding for health infrastructure improvement and public health activities, such as health promotion. This is the major difference between the NHF and other systems in the Caribbean region, such as the Barbados Drug Scheme and Trinidad and Tobago's Chronic Disease Assistance Plan. The government has increased the budget of the MOH out of general taxation revenue to compensate for loss of income from the abolition of user fees; however, it still has not met the increased demand or increased the financial protection. The government might consider increasing NHF funding from general taxation and using the NHF as financier for health services, particularly for the poor, while the better-off population can contribute through copayment based on their income level. This will further expand the pooling of financial risk for health care and improve equity in access to care.

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<sup>14</sup> Based on the discussion between the World Bank health mission and MOH policy makers in 2011 and 2012.

## **NHF as Health Service Purchaser**

The NHF treats public and private providers equally, and gives beneficiaries a free choice to select a provider. It encourages competition between public and private providers on service and price. This policy has not been implemented without controversy. Since its implementation in 2004, the majority of NHF beneficiaries have chosen private providers. That has raised the concern that public funds are being used to support the private sector. Others believe that allowing provider choice makes the NHF more efficient and increases the quality of health care services. Given that the prescription drug market is imperfect and that prices for life-saving drugs are inelastic, rigorous monitoring and regulation by the government are needed to avoid a monopoly by the private sector, particularly the pharmaceutical industry. The NHF's reference pricing policy and promotion of the use of generic drugs would affect the pharmaceutical market in Jamaica. The NHF has assumed procurement of drugs for public facilities; it would have more influence on pricing of drugs.

The current structure of the public health sector has limited mechanisms to finance civil society organizations and NGOs to carry out public-health-related activities, such as HIV/AIDS prevention and health behavior promotion. The NHF has already financed health promotion activities and could further serve as a purchaser for the government to finance public health activities. The Subcommittee on Institutional Benefits could call for proposals for public-health-related activities from both the public and private sectors. It could select the organizations that are best placed to implement these activities, with the result that NHF financing and payments can be based on results rather than on inputs.

The NHF has been a well-run entity, and the government is considering assigning it additional responsibilities. The first possible expansion of the Individual Benefits program is to transfer the financing and procuring of HIV/AIDS drugs from the MOH to the NHF. By doing so, the government could provide additional funds to the NHF. The MOH is assessing the feasibility of this transfer.

## **Expand Benefit Coverage under the NHF**

The benefit package under the NHF is limited. The level of out-pocket-spending is still high. The increased government financing through the MOH budget does not produce improved access or better health outcomes from the public sector. The NHF could serve as an existing mechanism and institution for the government to further advance universal coverage through three dimensions: breadth, depth, and extent of coverage. The breadth of coverage is the number of population groups covered. The depth of coverage concerns the types of services covered. The extent of coverage refers to the degree of financial protection.

- *Breadth of coverage.* As a first step, the NHF needs to expand its population coverage, particularly to the poor and vulnerable populations in remote rural areas. As a second step, the NHF could expand population coverage eligibility to cover more illnesses and more of the population. In addition to its normal targeting (focusing on age and type of illness), the NHF could consider geographic targeting,

by expanding enrolment in areas where poverty, disease, and violence are concentrated.

- *Depth of coverage.* If the government would like to use the NHF to achieve universal coverage, it needs to gradually expand coverage of services—not only more pharmaceuticals, but also more medical services. The NHF needs to assess both the effectiveness of the prevention programs it finances and the drug subsidy programs, and it needs to strike the appropriate balance between prevention and drug subsidy programs.
- *Extent of coverage.* The current drug subsidies cover less than 60 percent of costs, with 40 percent of the cost of drugs borne by patients. This high copayment does not provide patients with enough financial protection. Further expansion of the NHF could cover a higher percentage of cost through public funding. To increase financial protection and risk sharing, the NHF needs to further expand its pool of revenues.

### **Ensure the Financial Sustainability of the NHF**

Long-term financial sustainability requires the balancing of revenues against liabilities. The NHF has drafted a Strategy Plan for 2005 to 2030, “Securing the Future,” to understand more clearly the factors that affect its sustainability and identify strategies to address them. In developing this Strategy Plan, the NHF management reviewed each source of revenue and the key factors that affect the revenue and expenditures of the NHF program. Its diversified sources of income have provided the NHF with a more balanced revenue stream, which has made it less vulnerable to the changing economic environment. The global economic crisis that affected Jamaica led to a reduction in income from both tobacco and special consumption taxes in 2008, but income from the payroll deduction nevertheless has continued to increase, thereby increasing NHF total revenue.

The future increase of NHF resources will depend on general taxation. The tobacco excise tax is one of the three major sources of income for the NHF. Initially, the Strategy Plan estimated more revenue from tobacco excise taxes. Revenue from tobacco excise declined, however, when the major cigarette manufacturing plant relocated to Trinidad and Tobago in 2006. Payroll deduction then became the major source of financing for the NHF. The Strategy Plan does not envisage a major revenue increase from either payroll or special consumption taxes, with a result that no significant revenue increase is anticipated unless other sources of revenue are identified. The NHF Strategy Plan analyzes the future burden of disease and potential financing scenarios. To expand the benefit package in any direction, the NHF needs further financing from general taxation.

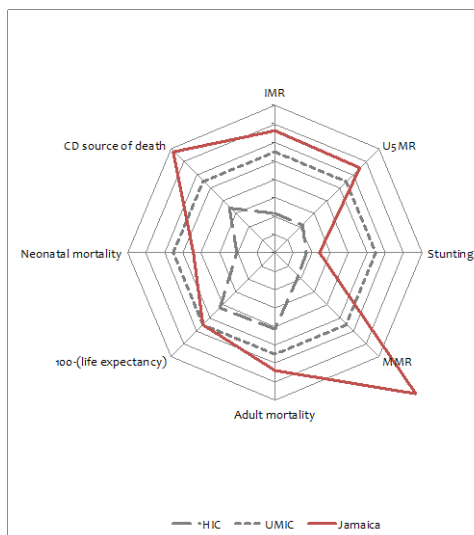
Sustainability will also depend on increased health care efficiency and effectiveness. With limited economic growth and a weak taxation system in Jamaica, the chance for revenue increases for the NHF from general tax is not likely. In the short term, the NHF will need to improve its efficiency through better targeting, better procurement, and reduced duplication and waste in the system.

## **Potential Future Development of National Health Insurance**

The design of the NHF was envisioned as a first phase in the development of a national health insurance plan. The NHF in its current form is far from being a national health insurance plan; it covers less than 20 percent of the population and provides limited subsidies for a limited list of drugs. However, it serves as an important building block for a move toward eventually providing universal access to health care in the country. For that reason, policy makers are considering expanding the benefits coverage of the NHF. One option under discussion is to allocate to the NHF the government budget that has been earmarked to replace the income loss from user fees, and to use the NHF as a purchaser and financier for the most vulnerable population, while at the same time expanding the benefit package to offer a wider range of health services. As the NHF gradually expands its functions and coverage, it would move toward the national health insurance model.

## Annex 1 Spider Web

### I. Outcomes comparisons: Jamaica and Upper Middle Income Countries

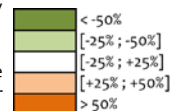


#### Note on interpretation:

In this plot 'higher' is 'worse' – since these indicators are positive measures of mortality / morbidity. Life expectancy is converted to be an inverse measure.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

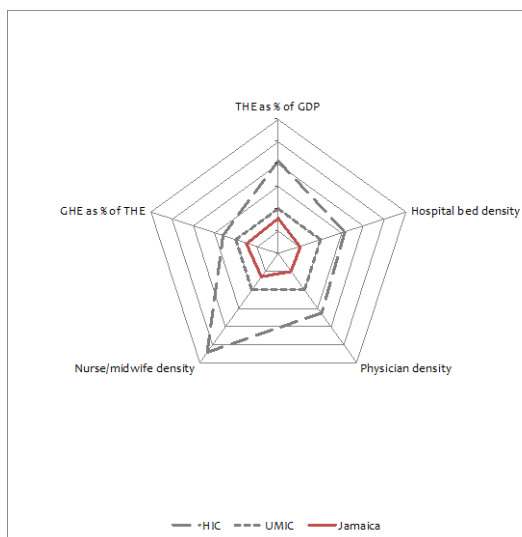
The table below summarizes outcome comparisons with the average upper middle income country (UMIC).



Country Data	Jamaica	UMIC	% Diff.
GNI pc (2000 USD)	3345.3	1899.0	76.2%
IMR	20.2	16.5	22.4%
U5MR	23.8	19.6	21.2%
Stunting	5.7	14.8	-61.4%
MMR	110.0	53.2	106.6%
Adult Mortality	188.5	160.6	17.4%
100-Life Expectancy	27.2	27.2	-0.1%
Neonatal Mortality	9.0	11.4	-21.1%
CD mortality	32.0	22.0	45.5%

IMR: Infant mortality rate (2010). U5MR: Under-5 mortality rate (2010). Stunting: prevalence of low height-for-age among children under 5 (2010). MMR: Maternal mortality rate (2010) per 100 000 live births. Adult mortality: Adult mortality rate per 1000 male adults (2010). [100-(life expectancy)]: Life expectancy at birth (2010) subtracted from maximum of 100. Neonatal mortality: Neonatal mortality per 1000 living births. CD as cause of death: Communicable diseases as cause of death (% total). All data from World Bank's World Development Indicators. Income averages for stunting calculated by Bank staff and are unweighted.

### II. Inputs comparisons Jamaica and Upper Middle Income Countries

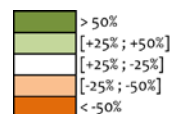


#### Note on interpretation:

This plot shows indicators which measure spending on health or the number of health workers per population.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

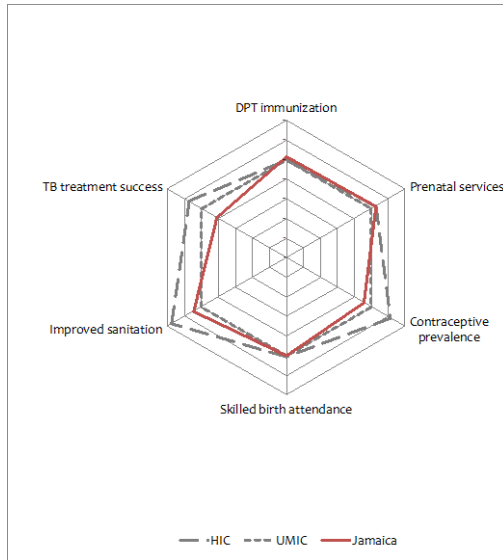
The table below summarizes inputs comparisons with the average upper middle income country (UMIC).



Country Data	Jamaica	UMIC	% Diff.
GNI pc (2000 USD)	3345.3	1899.0	76.2%
THE %GDP	4.8	6.1	-21.3%
Hosp. bed density	1.9	3.7	-48.2%
Phys. density	0.9	1.7	-49.7%
Nur./midwife dens.	1.7	2.6	-36.7%
GHE %THE	40.1	54.3	-26.2%

THE as % of GDP: Health expenditure, total (% of GDP) (2010). Hospital bed density: Hospital beds per 1,000 people (latest available year). Physician density: Physicians per 1,000 people (latest available year). Nurse/midwife density: Nurses and midwives per 1,000 people (latest available year). GHE as % of THE/10: Public health expenditure (% of total expenditure on health) (2010). All data from World Bank's World Development Indicators.

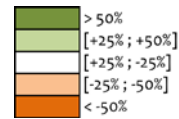
### III. Coverage comparisons Jamaica and Upper Middle Income Countries



**Note on interpretation:**  
In this plot 'higher' is 'better' – since these indicators are positive measures. In this case, all are percent of the population receiving or having access to a certain health related service.

The values on the radar plot have been standardized with respect to the average upper income country value.

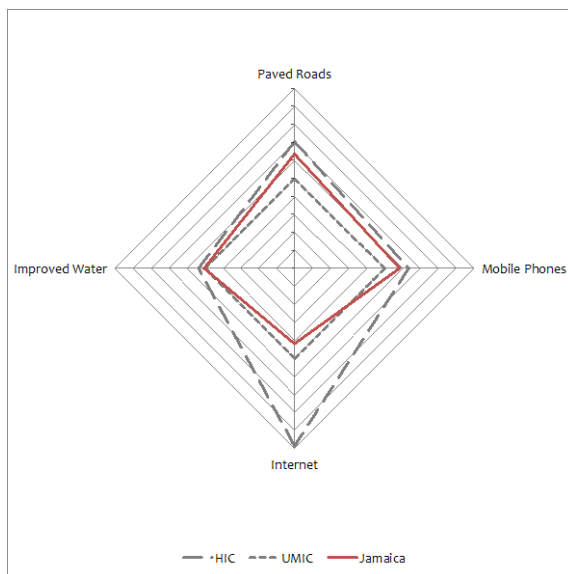
The table below summarizes coverage comparisons with the average upper middle income country (UMIC).



Country Data	Jamaica	UMIC	% Diff.
<b>GNI pc (2000 USD)</b>	<b>3345.3</b>	<b>1899.0</b>	<b>76.2%</b>
<b>DPT</b>	99.0	95.8	3.4%
<b>Prenatal</b>	99.0	93.8	5.6%
<b>Contraceptive</b>	73.7	80.5	-8.5%
<b>Skilled birth</b>	98.0	98.0	0.0%
<b>Sanitation</b>	80.0	73.0	9.6%
<b>TB success</b>	70.0	86.0	-18.6%

DPT immunization: % of children aged 12-23 months with DPT immunization (2010). Prenatal services: % of pregnant women receiving prenatal care (latest available year). Contraceptive prevalence: % of women ages 15-49 using contraception (latest available year). Skilled birth attendance: % of all births attended by skilled health staff (latest available year). Improved sanitation: % of population with access to improved sanitation facilities (2010). TB treatment success: Tuberculosis treatment success rate (% of registered cases). All data from World Bank's World Development Indicators.

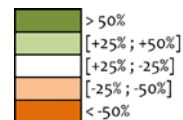
### IV. Infrastructure comparisons Jamaica and Upper Middle Income Countries



**Note on interpretation:**  
In this plot 'higher' is 'better' – since these indicators are positive measures of provision of certain good / service, and a measure of urban development.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

The table below summarizes infrastructure comparisons with the average upper middle income country (UMIC).

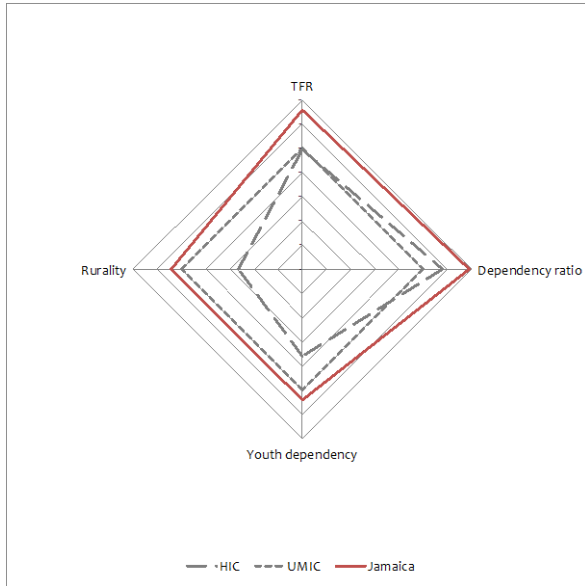


Country Data	Jamaica	UMIC	% Diff.
<b>GNI pc (2000 USD)</b>	<b>3345.3</b>	<b>1899.0</b>	<b>76.2%</b>
<b>Paved roads</b>	73.3	57.6	27.3%
<b>Mobile phones</b>	108.1	92.3	17.1%
<b>Internet</b>	32.0	38.3	-16.5%
<b>Water</b>	93.0	92.6	0.4%

Paved roads: % of total roads paved (most recent). Internet users: users per 100 people (2010, with some estimates from prior years). Mobile phone users: mobile cellular subscriptions per 100 people (2010). Access to improved water: % of population with access to improved water source (2010). All data from World Bank's World Development Indicators.



## V. Demography comparisons Jamaica and Upper Middle Income Countries

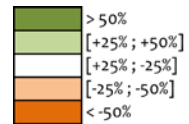


### Note on interpretation:

Indicators here measure births per woman, the extent of rurality, and the number of dependents.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

The table below summarizes demographic indicators comparisons with the average upper middle income country (UMIC).



Country Data	Jamaica	UMIC	% Diff.
GNI pc (2000 USD)	3345.3	1899.0	76.2%
TFR	2.3	1.8	31.6%
Dependency (Total)	58.4	42.2	38.3%
Youth share	78.8	73.0	8.0%
Rural pop.	46.3	42.6	8.8%

TFR: total fertility rate (births per woman), 2009. Dependency ratio: % of working-age population (2010) aged less than 15 or more than 64. Youth dependency: % of working-age population (2010) aged less than 15. Rurality: % of total population in rural areas (2010). All data from World Bank's World Development Indicators.

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The World Bank supports the efforts of countries to share prosperity by transitioning toward universal health coverage (UHC) with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, the quality of the instruments and institutions countries establish to implement UHC are essential to its success. Countries will face a variety of challenges during the implementation phase as they strive to expand health coverage. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Studies Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of 27 programs in 25 countries that have expanded coverage from the bottom up, starting with the poor and vulnerable. The protocol consists of 300 questions designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following:

- Manage the benefits package
- Manage processes to include the poor and vulnerable
- Nudge efficiency reforms to the provision of care
- Address new challenges in primary care
- Tweak financing mechanisms to align the incentives of different stakeholders in the health sector

The UNICO Studies Series aims to provide UHC implementers with an expanded toolbox. The protocol, case studies and technical papers are being published as part of the Series. A comparative analysis of the case studies will be available in 2013.



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