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Recent developments in health care

Selected experiences in Central America and the Caribbean

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Executive summary

Practically all countries in the Caribbean region have implemented or are planning to introduce health sector reforms. Recent trends indicate that most Spanish-speaking countries in the Caribbean and Central America which operated a traditional health insurance scheme are in the process of reengineering in its entirety the health delivery system, trying to improve accessibility of marginal groups and the efficiency of the scheme (Costa Rica), whereas others have embarked on a complex systemic reform with emphasis on effectiveness, quality, intersectorial coordination and community participation. Both reform models retain or assign an important, if not dominant, role to the health insurance component, striving to promote competition amongst public and private providers, and keeping a financing structure based on payroll contributions. In the English-speaking countries in the Caribbean, most national health schemes funded from general revenues are facing serious financial constraints. Ongoing projects aim to improve the health delivery system by establishing an autonomous health agency with the funding basis yet to be designed. The viability of these complex reforms depends on a proper assessment of the "forces in play", the administrative capacity of the country, and related risks. The implementation risks seem to be greater under a systemic or structural reform than under a reengineering of the health delivery scheme. It is also expected that greater emphasis on primary health care and prevention will improve the effectiveness of the fight against HIV/AIDS.

Background

Most Latin American and Caribbean countries have either implemented or are in the process of introducing health sector reforms. Despite rising per capita income in most countries, the efficiency and quality of national health services have lagged behind, and the share of health resources directed to the private sector has increased steadily. Most Spanish-speaking countries in the Caribbean sub-region included the "risk" of medical care for insured persons at the inception of their social security schemes, with financing based on payroll deductions (Mexico, Central American countries, Colombia, Venezuela and the Dominican Republic). A

statutory agency was in charge of the administration of the national pension and health scheme (institutional integration); with no efficient coordination with parallel government funded schemes operated by the Ministry of Health for the general population. This uncoordinated model was not sustainable, due to lack of resources and the poor quality of services in the public systems, and inefficiency and low productivity of the social security schemes, which survived in part with funds transferred from the pension scheme, contributing to the financial deterioration of the latter. On the other hand, the English-speaking countries in the Caribbean followed the health pattern of the United Kingdom: a National Health Service funded by Government, operated by the Ministry of Health, striving to offer universal access to the population. The financial constraints of the public sector have also affected the quality, effectiveness and sustainability of these programmes.

This report focuses on health sector reforms in specific countries in the Caribbean region, and the "new" role of social insurance in these reforms, a reflection on the worldwide search for alternative solutions in health care services, which are diverse in nature but, as highlighted by Aichman (Aichman, 1998), have some similarities and confront common challenges.

Characteristics of health system reforms

The health sector reform, strategies and initiatives in developing countries aim to achieve maximum economic and operational efficiency, attain financial sustainability, promote competition, provide equity, solidarity and effectiveness, and improve the quality of services. These policies have emphasized the integration/coordination of the health services, decentralizing the administrative function, mobilizing additional resources, restructuring the financing mechanism, and shifting the utilization pattern to primary health care. In general, the basic objective is to improve the health status of the population. To achieve these complex and multiple goals most countries have embarked on health system reforms, which are being tackled by each country according to specific modalities and priorities, as outlined below.

Some developing countries (and most market economies) have opted for an integral reengineering of the health delivery system, having regard, to the extent possible, to the existing model of health care in place in the respective region. Others have chosen a structural or systemic reform, involving the complete overhaul of the health delivery model in place. Other reforms fall in-between these two extremes. Although it is difficult to categorize precisely the health reform model in a specific country, for ease of presentation these denominations are used in this report.

According to the key objectives, policy options and an appropriate action plan can then be identified, as highlighted in a comprehensive regional study sponsored by international organizations (Inter-American Development Bank (IDB); Pan-American Health Organization (PAHO) (IDB; PAHO, 1996). Equity requires policy options targeting universal coverage and access to basic services, which also requires a basic package of Primary Health Care (PHC) and subsidized secondary/tertiary care for the poor. Effectiveness and quality requires reengineering of the health system and addressing weaknesses in the provision of essential services, the optimal allocation of health personnel and facilities, and the allocation of resources on a more cost-effective basis. Financial sustainability requires public expenditure targeted to the poor, developing complementarity between private and public finances, introducing cost-sharing for specific services, separating the provision of services and the financing functions, and retention or adoption of social insurance principles as the dominant financing mode. Institutional and community participation requires appropriate coordination

of the ministries and entities involved in the health sector, and involving stakeholders in the design, planning and administrative process. But when there are priorities in all these key areas, the complexities involved in a systemic reform of the health sector become evident. It should also be stressed that the role of social health insurance is not limited to the key objective of achieving financial sustainability, since such programmes can also play an important role in the efficiency and effectiveness of the health sector.

The forces at play

Although economic, social and medical considerations are primary factors to be considered in the health sector reforms, the urgency to reform should not overlook specific factors to be entered into the "reform equation". Abel-Smith (Abel-Smith, 1996) stated that, usually, key factors were ignored in many developing countries when designing health sector reforms. Preliminary policy assessments were converted a few months later into specific proposals, disregarding key elements such as whether the reform overestimated the administrative capacity of the country to manage, administer and supervise the new model, or whether the proposed scheme would conflict with the national culture or be conducive to more inefficiency, inequality and abuse. Hence, a careful analysis of the "forces at play" is essential for a successful outcome of the reform, avoiding the temptation to imitate the reform model of another country. Guidelines are shown in Box 1, adapted from McGillivray.

Box 1

The forces at play

The medical profession – whose inclination is to:

?? maximize their income (can induce demand and generate moral risk);
?? use sophisticated technology;
?? ignore health economics (emphasis is on science and ethics);
?? accord a secondary role to management and efficiency.

The patients

?? consider medical care has no price when ill;
?? place complete trust and have a high regard for the physicians;
?? are unequal participants in the market for medical care;
?? can increase demand subject to elasticity.

Governments

?? regard health as a social priority but there are competing demands;
?? burden on public finances are imposing constraints on the allocation of needed resources;
?? are relying more heavily on the recommendations of international agencies and outside experts due to collateral financing facilities;
?? realize that their policies can only have a marginal impact on the efficiency of the health sector.

Employers

?? realize the impact of the sector on their cost and productivity;
?? are willing to co-participate in the reform process and increase their basic tax burden to avoid duplicate costs;
?? expect more efficiency but ignore the complexities of the system.

Experts (International agencies and consultants)

?? accord themselves a high level of self-esteem and the capacity to design the "right" model. Usually have pre-conceived ideas on the reform model

Country-specific trends

Costa Rica

Costa Rica spends 9 per cent of GDP on health services, the highest proportion in Latin America, of which more than 80 per cent is public expenditure, mainly from social security payroll contributions of 15 per cent of wages paid by employers and employees (and 12.25 per cent of pensions). The health system is managed by the Social Insurance Fund of Costa Rica (*Caja Costarricense de Seguro Social* (CCSS)). More than two decades ago, the Ministry of Health transferred its medical infrastructure to the CCSS, but retained a regulatory role over the health sector. Private providers of medical care are very limited but the reform envisages greater competition, and the private infrastructure is expected to increase gradually. Coverage of the CCSS is rather high (85 per cent of the labour force) and access to the services is universal. Despite the significant resources devoted to health care, consumer satisfaction is not very high, with widespread complaints due to long waiting periods, cumbersome administrative procedures, and poor quality of services. However, technical assessments indicate that the health scheme in Costa Rica shows the highest rank as regards access, equity and effectiveness in the Central American region.

The CCSS has initiated an ambitious multi-year reform project, with the objective to improve the efficiency and effectiveness of the scheme (Piza Rocafort, 2001). The reform aims to decentralize the provision of primary health care, by establishing "basic teams" (*Equipos Básicos de Atención Integral a la Salud* (EBAIS)) throughout the country, serving population units of 4,000 persons. Each team is composed of a family doctor, a nurse and a community worker operating out of small clinics. Coverage of the EBAIS had reached two thirds of the population in 2000. The reform also aims to modify the allocation of resources at the first level of medical care, with the gradual introduction of "per capitation" payments to providers, and to initiate the de-linking of the financing and the provision of health services, giving providers performance incentives and a better control over how their budgets are spent.

It is expected that once the reform is concluded, the more efficient use of resources will improve the quality of health care in Costa Rica without an increase in the level of health expenditure.

Belize

In Belize, as a component of the health sector reform project, international financial organizations sponsored extensive studies on health reform, including the option of setting up a formal independent central authority to manage the national health scheme, or establishing an entity as part of the existing Belize Social Security Board (SSB), but with operational autonomy and separate financing arrangements. The scheme would be co-funded by part of the budget allocation to the Ministry of Health and special Government transfers targeted to the poor, but a new payroll tax assessed on insurable earnings would become the dominant financing basis. After considerable discussion it was decided to manage the scheme as an independent branch of the SSB. A pilot project, funded by the SSB, should be concluded in the first-half of 2002. Specific risks and constraints should be overcome before the scheme becomes operational, including setting in place the organizational reforms, the complex operational procedures, and obtaining the agreement of vested interest groups (insurance companies, unions and employers). However, private medical providers seem to support the reform since they stand to gain a greater participation as providers of medical care to the general population. This process was initiated in 1999

when the SSB's employment injury branch included the private medical sector as co-providers of medical services. A key constraint might be the willingness of stakeholders to commit themselves to financing a prepaid compulsory national health scheme, although studies have shown that premiums would offset expenditure in private insurance plus direct out-of-pocket expenses. Widespread utilization of medical facilities in neighboring countries (Guatemala and Mexico) should diminish substantially, with considerable savings on foreign currencies once the national medical infrastructure is modernized and the quality of services improves. Tentatively, the scheme should begin operations by late 2002 or in 2003 and, despite the stated government intention of a universal health scheme for the total population, a gradual implementation process should not be ruled out, starting with the salaried population insured by the SSB.

Total health sector expenditure is higher than the regional average, estimated at 7.3 per cent of GDP, of which 78 per cent (5.7 per cent of GDP) is spent directly on services. Of this total, private expenditure accounts for 59 per cent, of which 40 per cent is spent abroad. The quality of public services is perceived by the consumer as being of low quality and, hence, the proposed reform should improve the efficiency and quality of health care by redirecting the allocation of resources within the health sector, provide access to private medical services, which are very costly on a direct basis, and control the proliferation of unnecessary services outside the country. Box 2 shows key features of the reform, adapted from Garcia (Garcia, 2001) and others.

Box 2

The proposed national health insurance scheme in Belize

?? Administered by the Belize Social Security Board.
?? Ministry of Health's role: regulatory agency.
?? Tripartite funding: bipartite payroll contributions + Government transfers targeted to the poor.
?? Key objective: to modify the allocation of resources: Improve access and efficiency: reduce the preponderance of direct expenses (out-of pocket or co-payments) from:
Pre-reform: 58 per cent
Post-reform: 10 per cent.
?? Gradual reduction in expenditure outside the country envisaged.
?? Public/private providers of primary health care: financed on a capitation basis.
?? Hospital care: allocation of resources based on performance contracts, the volume of services, results and user satisfaction.
?? Government hospital: shift to self-government status.
?? Emphasis on PHC, including standard evaluation of HIV/AIDS status.

Dominican Republic

In the Dominican Republic the private sector supplies more than half the demand for health services and receives 75 per cent of total health expenditure, estimated at 6.3 per cent of GDP. The country recently enacted a new social security law providing for a radical structural reform of a three-pronged health delivery system: (a) Ministry of Health (indigent and low-income population); (b) private providers, with an increasing share of patients; and (c) the Dominican Institute of Social Insurance (*Instituto Dominicano de Seguros Sociales* (IDSS)), covering insured persons, although more than half of the IDSS's insured persons prefer private services, and have obtained such benefits as standard "conditions of employment" in the formal sector of the economy. Each sector dispenses services in its own medical infrastructure. The result has been a costly and inefficient social insurance

programme run by the IDSS, double taxation of employers and workers (IDSS and private services), and lack of intersectorial coordination.

The new law allows the worker to select voluntarily a Health Risk Administrator (*Administradora de Riesgos de Salud* (ARS)) for services in the private sector, or in the National Health Insurance ((*Sistema Nacional de Salud*) (SNS)) public scheme, a system with some similarities to the Chilean medical scheme. The ARS or the SNS will in turn pay Providers of Health Services (*Proveedoras de Servicios de Salud* (PSS)). Payroll contributions will be paid to a centralized Treasury, which in turn will pay either the SNS (public) or the ARS (private) a per capitation fee, and these entities will in turn pay the providers according to specific tariffs. A transition period is envisaged wherein the actual IDSS will retain, as a public provider, insured persons not affiliated by the employer to a private provider.

The scheme will only offer a basic package (as yet undefined), and employers or employees may opt to purchase supplementary services from the providers. Due to the diversity and extent of private providers in the country, and the complex structure required to operate and supervise the proposed system, there is at present scepticism that the reform will be able to provide a platform to operate an efficient national health scheme.

Recent trends in the English-speaking Caribbean

Hardly any of the dependent and independent Commonwealth members in the English-speaking Caribbean operate a formal social health insurance scheme. The region is characterized by a dominant role of the public health sector and thus, high sensitivity to constraints in government spending, and a high-share of offshore and out-of-pocket expenses for diagnostic services. Access to care is theoretically dispensed to the general population by medical facilities operated by the Government and funded by general revenue, but sometimes a fee-for-service is charged to the patient based on a means test. Pre-paid health insurance contracts with insurance companies are very common for salaried workers in the formal sector of the economy, including civil servants, since the public facilities can only offer a very limited range of basic services. Utilization of services outside the country is very intense. However, the health status, as compared to other developing countries, is reasonably good, with the exception of Guyana and French-speaking Haiti.

A comprehensive study sponsored by the Inter-American Development Bank and the Pan-American Health Organization (IDB; PAHO, 1996) categorized the reform projects under consideration in the Caribbean countries. The most frequent activity was the introduction of national health insurance schemes (10 out of 13 countries in the survey), followed by decentralization and community participation (9 countries), the introduction of user fees (8 countries), as a cost-containment mechanism, and multisectoral integration. In contrast to most Spanish-speaking countries in the Caribbean region, financing by general revenue seems to be favored over a payroll tax, but the issue is still under consideration since this might increase the "health resource gap" between, on the one hand, the rising cost of health services, and the availability of health resources due to stagnant economies and the demands of other social sectors.

Strain on public finances has prompted governments to carry out studies to set up national health insurance schemes. Specific experiences are summarized below: **Bahamas**: set up a tripartite Working Party on National Health Insurance (1984-1987), and a subsequent Task Force submitted its final report in 1991. No action was feasible at the time. More recently, technical assistance has been provided by an international organization to set up initial

coverage for catastrophic illnesses (major medical cases), but implementation does not seem forthcoming in the near-term. The Bahamas has the highest income per capita in the region and health expenditure, estimated at more than 5 per cent of GDP, has a very high component that is spent abroad. Unprecedented economic progress in the last decade allowed the Government to finance the rising cost of medical services in public facilities, a scenario that might change during the present decade. **Jamaica:** has proposed a pre-paid health plan (PNP) targeted at low-income persons not covered by private insurance. The project is still under review. **Suriname:** operates a State Insurance Fund (mandatory health insurance for government workers). In the 1990's the Fund began to face financial problems, undermining its insurance function. The scheme is currently under review. **Antigua:** operates the Medical Benefits Scheme (MBS), a limited programme supervised by the Ministry of Health to address specific diseases. Funded by bipartite contributions of 7 per cent of wages paid to certain salaried workers. The system is under review. **Trinidad and Tobago:** plans to set up a national health insurance scheme funded by a payroll tax. **Anguilla, Turks and Caicos Islands, etc.:** there are ongoing primary projects to set up national health insurance schemes.

Stumbling blocks for health reform

Overestimation of the administrative capacity of the country, structural reform models that clash with or ignore the national culture, and underestimation of the "forces at play", could be identified as some of the stumbling blocks for an effective health reform in many countries. In the meantime, public sector inadequacies due to lack of financial resources continues to deepen in the region. Other relevant factors are: shortage of qualified staff, insufficient supplies and poorly maintained equipment, deteriorating infrastructure, and a shift of preference and demand for private health services. With this scenario, the inclination to introduce structural reforms rather than to reengineer on a gradual or incremental basis the existing model could entail difficulties in the effective introduction of reforms. While Costa Rica, after consolidating public hospitals in the CCSS almost three decades ago has introduced gradual reforms to the national health insurance programme by reengineering its traditional scheme; the Dominican Republic has enacted a complex law providing for a centralized payroll collection statutory agency responsible for paying dozens of heterogeneous private providers on a capitation basis every month. The new system is targeted to become effective within a year, in a country where more than half the providers belong to the private sector, which already operates an extensive network of Health Maintenance Organizations (HMOs) and private insurance packages based on a pre-paid basis.

In some countries the health sector reform model is "predetermined" by external consultants, based on their own national experiences and with minor adaptations, disregarding an established pattern of health care that took decades to set up. Hence, all countries face varying degrees of "implementation risk". The implementation risk deals with the failure of a health reform project to become operational by the target date or to become efficient at the inception due to faulty design. Experience shows that critical success in implementing a structural reform as in the Dominican Republic or Belize, or reengineering the delivery framework as in Costa Rica, takes between 5 and 10 years. The problem lies with the reform model, which in Costa Rica is an adaptation whereas in the other two countries it is a new system. Intensive technical evaluations are ongoing in Belize and the Dominican Republic but, in the latter, the law already specifies a rigid modality to provide payment by capitation to a heterogeneous net of "insurers" (IDSS, insurance companies, HMOs) who in turn will have to put in place payment mechanisms to medical providers at all levels. The fragmented

scheme that will result contrasts with the more homogeneous structure of the health funds in Germany or the consolidated system in Costa Rica.

A World Bank study (World Bank, 1987) confirms that implementation of health reforms in developing countries takes considerable time. Charges in administrative support systems, to differentiate the poor from the not so poor, the gradual pace of decentralization, local decision making, and the ability for record keeping (financial and medical), illustrate the difficulties involved in the reform of a health system. Furthermore, most countries in the Caribbean fulfill the necessary pre-conditions for social health insurance, funded through a system of payroll contributions, as stated by Normand and Weber (Normand; Weber, 1994).

Moral risk and health gains

The assertion that an increase in the coverage of "reformed" health schemes would trigger an increase in the demand for services (moral risk) should be taken into consideration and influence the reform model of health schemes in the region. The moral risk on the "demand side" (patients) could be an incentive for excessive use of health services due to the lower cost of services. Some services may show "price sensitivity" or elasticity in the demand, which is limited to "elective" services (Dror, 2000). Non-elective chronic services are inelastic, since the demand is independent of the cost or the supply of services. Control of the demand can be achieved by restructuring the benefit package to well-defined risks of low frequency (catastrophic or tertiary care), but this goes against the principles of integral services embodied in the reform projects in the area. Another option would be to increase co-payments at the point of delivery, an option chosen by the Republic of Korea in the introduction of a health insurance scheme with a low contribution rate, a reform that has been successful so far.

On the "supply side" the medical provider could augment the "induced demand" to increase payments by the insured, either a private entity or a public agency. Hence the payment mechanism to the provider should be carefully evaluated, having regard to the fact that the medical profession usually does not accept outside interference in its professional judgments.

Moral risk could be relevant in the reforms in the Dominican Republic and in Belize, with a significant component of private providers, although the financial autonomy to be introduced in public hospitals could also generate an increase in the induced demand by the provider, jointly with a payment mechanism based on a specific tariff. Hence the real moral risk will be borne by the insurer (the ARS in the Dominican Republic) who, by confronting losses, could demand an increase in premiums or higher co-payments.

Of particular interest is the cost-efficiency element intrinsic in the reform, that is, achieving the greatest "health gain" on the financial resources allocated to health, or, as Normand (Normand, 1993) states, combining longer life and better health standards. However, complexities in quantifying variations in health gains do exist and, for most developing countries, a strategy of changing the composition of health expenditure may be more important than increasing the level of financial resources in determining health outcomes, with life expectancy as the primary measure of health gains (Cichon et al., 1999).

Micro-insurance

Micro-insurance, a mechanism to increase the provision of health services and to facilitate access to segments of the population excluded from general health services, is not prevalent or latent in the English-speaking Caribbean countries. This is due in part to the small size of the countries and their "marginal" population, facilitating access by the client base to the public provision of primary health services – the specific focus of micro-insurance. Further, micro-insurance has a different dimension from "community-based" services, although there is a close link between the two (Dror; Jacquier, 1999). The concept of micro-insurance as "voluntary" self-help schemes for social health insurance, based on social needs, has been implemented on a very limited scale in some other countries in the Caribbean sub-region, as part of the International Labour Office (ILO)'s STEP project (*Stratégies et techniques contre l'exclusion sociale et la pauvreté* - Strategies and Tools against Social Exclusion and Poverty), although its potential seems to be more relevant in the African region. The experiences in the Caribbean (Colombia, Honduras, Dominican Republic and Nicaragua) show that, with the exception of Colombia, coverage has been rather low in relation to the target population (ILO; PAHO, 1999). Further, very serious obstacles remain to ensure the financial and institutional sustainability of these projects, including the "voluntary" nature of the micro-insurance concept, adverse selection, non-dependence from subsidies, capacity to self-manage the scheme, and the affordability of the target population to self-finance its share of the operational cost.

Categorization of health reforms

Based on the assessment of country specific trends, Box 3 shows a specific categorization of the ongoing or projected regional reforms. Obviously, the level of resistance and the implementation risk are greater under a systemic or structural reform than under a gradual reengineering of the scheme.

Box 3

Categorization of health reform indicators in selected countries*
(Ongoing or projected)

	Costa Rica	Belize	Dominican Rep.	CARICOM States
?? Characteristic of the Reform	Reengineering NHI	Introduce NHI	Systemic NHI reform	Introduce NHI
?? Basic financing	Payroll tax	Payroll tax	Payroll tax	Budget
?? Target date	Ongoing	2002	2003	Not defined
?? Level of private services	low	low	high	low/medium
?? Utilization of services abroad	low	high	low	high
?? Level of resistance				
Private Providers	low	low	high	low
Employees / employers	low	medium	medium	n/a
Medical profession	low	low	high	low
Insurance companies	-	medium	high	medium
?? Implementation risk	low	medium	high	n/a
?? Moral risk	low	high	high	n/a
?? Feasibility of critical success	high	medium/high	low	medium
?? Adequate administration platform	feasible	feasible	complex	n/a

n/a: not ascertainable at present.
* Assessment of the author.

Impact of health reform on AIDS

The fragmentation of the health sector in many Caribbean countries is not conducive to effective prevention and control measures against the epidemics of HIV/AIDS. A national health insurance scheme with a centralized information system can allow a more effective design and implementation of AIDS prevention policies, than separate actions by the Ministry of Health, a social security agency, and HMOs. The greater emphasis on equal access and community based medicine in several countries in the region provide the best scenario for prevention and treatment of HIV/AIDS, with an incidence of new cases showing an increasing trend in the region. Cuba, despite severe financial constraints, has been able to put in place an effective health-education and prevention campaign resulting in one of the lowest rates of HIV/AIDS cases in the Western Hemisphere, which has become a leading cause of death in several countries in the Caribbean. Accurate diagnosis, provision of community care, financial resources and quality assurance at the laboratory level are amongst the key issues to control the transmission of AIDS, and these elements should form an integral part of the reform of the national health sector.

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