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Caribbean: Where Do We Go From Here?
Health Financing and Health Reform in the

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HEALTH FINANCING AND HEALTH REFORM IN THE CARIBBEAN: WHERE DO WE GO FROM HERE?

Introduction

In the face of a high level of activity in respect of health sector reform it is interesting to observe that the objectives which countries set themselves were remarkably similar. They included laudable goals such as equity, efficiency, and quality. In a PAHO/IDB document recently published for the CGCED a similar point was made about health sector reform in the Caribbean. In this case the list of objectives included:

i) equity and access;
ii) effectiveness and quality;
iii) efficiency;
iv) financial sustainability; and
v) intersectoral collaboration and community participation.

These are terms we now hear very often although it is not always clear what they really mean. What is certain is that the health sector reform process is fast becoming an industry in this region with significant resources of time, effort and finances being poured into a range policy initiatives. What is not at all certain is whether the impact of these reform efforts has been to point the sector in the direction desired. The nagging feeling among many health professionals and probably among large sections of the population is that the reform process so far...
has really been much more about talk than about anything really new. The requirement now is for an implementation bias. This is precisely the slant taken in this presentation.

It is within this context of dissatisfaction that at least one re-unit project in train has zeroed in on the management of the health reform process. The hypothesis of the project is that the management of the reform process itself is in need of reform. In the spirit of this hypothesis, the present discussion seeks to make the point that the health financing reforms being considered must be seen in a new light. For one thing, it is probably a theorem of health sector reform that the financing reforms cannot be considered to be on the same level as other more administrative reforms being undertaken. The simple reason is that these latter reforms require the kind of behavioural change which can only be brought about by financing reform. By the same token, the point can also be made that if financing reforms are to address the development concerns of the citizens of the Caribbean they cannot be seen in purely national terms. This is because in this region the objective of financing reforms — greater access to better services — cannot be considered in national terms.

The present discussion will be developed in three parts. The first will provide a bird’s eye view of the existing health financing systems in the Caribbean and then examine the imperatives for bringing about a change in the existing system. The second part of the discussion will consider the criteria which should inform the new health financing system. In this section, we will also take into account the fact that some countries have already initiated major reforms in their health financing systems. The third part of the discussion will provide a brief evaluation of regional efforts at health financing reform and outline the way forward for health reforms and health financing in the Caribbean.

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3 The PAHO/UNDP Health Sector Reform Management Project
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PART 1

Existing strategies and Reform Imperatives

1. It is no doubt true that the governments of the Caribbean have always accepted that theirs is the full responsibility for ensuring that all citizens should have access to proper and timely health care. However, this commitment has never really been translated into a requirement that the government is solely responsible either for the delivery or the financing of the health services that all citizens will require. The evidence suggests that opportunities for private involvement both in financing and delivery have always been profitably made use of in this part of the world.

2. From the point of view of the government the hallmark of the strategy of health financing in the past is captured in the phrase, *shared responsibility*. In a broad sense, the government has traditionally financed the bulk of primary preventive care as well as most of secondary and tertiary care. However, a substantial portion of primary medical care and an important component of secondary care has been financed out-of-pocket, with only a fraction by means of private insurance. In other words, this principle of *shared responsibility* has led to the emergence of a *mixed* system of health financing, albeit one whose structure has been changing over time. The basic source elements of the present system are:

(i) *Government Revenues*, which in most of our countries is still the dominant pillar of the present health financing system;

(ii) *Private Insurance*, which covers less than 25% of the population of the region at rates which are in fact subsidised by the public health system, and covering mainly a portion of the primary medical/curative expenses as well as a usually limited component of in-patient, pharmaceutical and diagnostic expenses;
(iii) **Social Insurance**, which in some countries covers a section of the population for a part of in-patient expenses and/or a defined set of pharmaceutical or diagnostic expenses;

(iv) **Out-of-pocket payments**, which cover user fees at public institutions as well as payments made to private providers of goods and services. In most countries of the region this component is emerging as a larger share of total spending on health care. Recent evidence suggests that the private/public split in financing is not as skewed in favour of public expenditure as is sometimes assumed.

3. On this last point the available data indicate that on the average national spending on health in the Caribbean shows a narrowing gap between public and private sources, with a slight bias still towards the public sector. The Table below shows that the private share of spending ranges between 31 and 55% while the public share is between 45 and 69%. We need to be cautious about our interpretation of these data since private health expenditures include a profit component which public health expenditures do not. Moreover, utilization patterns may be very different across the two sectors.

4. While it is certainly true that it is the effectiveness rather than the level of public expenditure which impacts on equity, the trend in public spending will have to be closely monitored. One of the real challenges of health sector reform is to organise the use of the different components of financing in a way which addresses the equity requirements of the population of the different nations.
**NATIONAL HEALTH EXPENDITURE IN THE CARIBBEAN, 1995:**

- Health Expenditure shares, NHE/GP;
- Per capita health expenditure, NHE/POP
- Public/Private percentage shares, PUB/PRIV

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<thead>
<tr>
<th>Country</th>
<th>NHE/GDP</th>
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<tr>
<td>Caribbean</td>
<td>5.1</td>
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<td>57/43</td>
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Average

Source: PAHO/HDD Data Base on National Health Expenditure and Financing, 1997
5. The Caribbean is justifiably proud in regard to its aggregate health indicators, life expectancy and infant mortality, in particular. Our indicators compare favourably with countries which are more developed and which spend much more on health than we do\(^4\). However, there is a definite concern that behind these aggregate indicators there is a less aggregated picture which most policy makers find uncomfortable.

6. Although sketchy, the available information on access to health services points to an unevenness, which is probably responsible for the observed negative impact on the health status of deprived groups. Added to this, the overall fiscal stringency and the implications for allocations to the health sector, have been the major basis of the call for moving to a financing strategy which would foster universal access. The concern is now with the vulnerability that comes from changes in the government's fiscal position as well as with the growth of a profit-oriented private sector in the delivery of health services.

7. The access problem is serious partly because it emerges in spite of relatively substantial public expenditures, which have been presumably aimed at yielding relatively greater benefits to the less well off. For example, the fact that secondary and tertiary care account for the lion share of public health spending in a context where the major beneficiaries of secondary and tertiary institutions are not the poor is a prima facie indication of an inequitable allocation of resources.

\(^4\) In many countries life expectancy is now between the low to middle 70s, reflecting a dramatic improvement over the past 40 years.
PART 2
Towards a new financing system

6. What seems to be required is a health financing system that gives explicit recognition to the need to address the situation of the poorer members of society. What this tells us is that one criterion of success of health financing reform would be the extent to which it reduces poverty in the different countries. In a context of limited fiscal resources with a sizeable share of hospital expenditures, it is tempting to see the health financing problem as a hospital problem. Yet the truth is that ever since Alma Ata it should have been clear that our intense focus on hospitals needed to be adjusted. To the extent that hospitals are not vitally important to the health status of the poor, the focus on hospitals increases inequity in the health system. However, it is not simply a matter of shifting resources from the hospitals to the primary care system. The challenge is to properly define the role of hospitals in the context of a financing system that gives primacy to wellness as opposed to sickness. The emphasis will then be on the timeliness of the contacts made with the health system.

7. To understand what the new arrangement will look like it is useful to begin with a short review on the nature of a health financing system. We note first that a system governing the payment for health services really addresses four distinct but related questions:

i) Who pays?
ii) What is being paid for?
iii) How are providers reimbursed?
iv) What is the impact on the cost and the quality of health services?

By its very nature the impact of a financing system is determined by the incentive system which is embodied within it. It is the incentives which
emanate from the financing system which act as a lubrication for the
delivery system. It is therefore the financing system which will influence
the behaviour of both users and providers of services, and therefore the
efficiency and equity outcomes of the health system. The incentive system
becomes especially crucial when the health system comprises both
providers and users who operate both in the public and the private sector.
In the effort to balance cost efficiency with equity one key feature of the
new financing system will therefore be the role assigned to the private
sector.

8. The need to articulate the public and private sectors as interdependent will
be a paramount requirement of the new financing system. If, for example,
the remuneration component of the financing system is such that public
sector providers with private sector privileges are better rewarded in the
private sector then the quality of service in the public sector is likely to be
compromised. Similarly if providers are everywhere better rewarded for
delivering secondary and tertiary care, then the service bias of the health
system will be on secondary and tertiary care solutions. Finally, if the
financing system is such that users are deterred by cost barriers from
accessing primary care in the private sector in a timely fashion then their
eventual (secondary) contact with the health system will certainly be more
costly to them and to the public health system.

9. The predominant concern of the health financing system is not with
deficit and surpluses but with the impact on the health of the
population. This is why the impact of the financing system on the
 provision of services becomes paramount. If the health impact of the
financing system is to be maximized then the new system must send
appropriate signals to both the users and the providers of care. What this
means is that the financing system will have to be closely monitored for its
impact on the cost of health care services, the access to health services
and the quality of those health services. The financing system must be
seen first and foremost as an instrument for getting the health system to reach more people and to work better on their behalf, not simply as a means of reducing the health care burden on the government’s budget.

10. At a recent international conference on Health Sector Reform in London one of the main lamentations was the lack of good information on the impact of different financing systems on health status. Given our present policy imperatives it will be important that in the Caribbean more time and resources be devoted to understanding and monitoring the link between our financing systems and the health status of our populations.

**New strategies, tried and intended**

10. So far we have pointed in a general way to the kind of financing system which is now needed. However, in the search for a health financing strategy which will work in the Caribbean it would seem that there are four steps that are required at this time:

- **i)** Each country must once more develop a clear picture of the kind of delivery system it would like to see in the future – spelling out carefully the roles of the public and the private sectors;

- **ii)** Each country will need to invest in improving its understanding of the experience of health financing in this region and in other countries like ours – we cannot afford to reinvent the wheel;

- **iii)** Each country must seek to identify the institutions and the mechanisms through which the consensus required for implementation of the new financing system will emerge – a workable financing system cannot be simply inserted from outside into the Caribbean health system; and

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5 Eighth Public Health Forum, referred to earlier.
6 The Eighth Public Health Forum hosted by the London School of Hygiene and Tropical Medicine, April 24th to 28th 1998.

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iv) Each country must now seek to pull together the best information available describing the disaggregated features of the health system and the socio-economic context in which proposed financing systems are being introduced. In other words the time has come when we must all know how health conditions are distributed among the population. How, for example, are morbidity and mortality related to income? How is access to health services related to the health status of the different socioeconomic groups?

11. In this regard there are three quick points which need to be made:

i) The historical data portray a remarkable consistency in the allocations made by our governments to the health sector - the problems that have emerged are therefore not related to a lack of budgetary commitment by the governments;

ii) International experience now seems to have brought us to the conclusion that the observed shift to private spending as a major component of health spending has been correlated with a worsening of the equity situation in health;

iii) The internationally established link between poverty and ill health together with the portrayal of pockets of appalling poverty in many communities in our several countries, emphasizes the urgency of reforming the financing system into a more effective instrument for improving the social conditions of our populations through an improvement in their health security.

12. How have our countries been responding to the health financing reform imperative? In some of our countries we have already witnessed a general shift away from general revenues, either by the introduction of user fees\(^7\) or the encouragement of greater use of
private insurance. We have also seen the introduction of a limited forms of social insurance;

13. Finally we have been witnessing a more serious consideration of universal National Health Insurance with a view to making it the dominant pillar of the health financing system.

PART 3
Evaluation of new approaches – The Way Forward

14. The international lack of information referred to earlier, in respect of evaluating the impact of different health financing systems, certainly applies to the Caribbean. However, probably the main weakness of the new private financing approaches mentioned so far has been the attempt to link them with decentralization initiatives. There is no question that in some countries the emphasis on decentralization of services or statutorization of public facilities has been directly linked to the drive to institute user charges. However this process has been characterized by the absence of a new signaling system for the purpose of attaining quality assurance, minimum cost and equity.

15. It is possible that part of the explanation for this lack of a new signaling system is the misguided belief that the decentralization of the services side of the health system and the attendant administrative reforms would have a distinct efficiency bias. This is a serious consideration since the empirical evidence available does not suggest that decentralization is the efficiency tool it is sometimes made out to be.

16. The second part of the explanation for the apparent muted impact of the changes instituted so far is the fact that health financing reforms have been usually seen in purely revenue-generation terms.

8 St. Kitts & Nevis, and Dominica
9 Antigua & Barbuda and Suriname
10 Jamaica, St. Vincent & the Grenadines, St. Lucia and Trinidad & Tobago

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17. The user fee reforms, for example, have been treated mainly as a fiscal device to relieve the burden on the State. There are two points which must be made at this point. First, the international evidence suggests that the user fee mechanism is usually not a significant revenue contributor to the health system. What is worse, however, is the evidence that this mechanism is now known to have the unwanted effect of delaying or avoiding contact with the health system on the part of low-income persons who may then present later in poorer health and with more costly health needs.11 In order to avoid this latter outcome the experience in the Caribbean with the introduction of user fees has been to build user fee systems either with explicitly generous exemptions or with weak billing and collection infrastructure. The net effect is that user fees in the Caribbean have not featured as a significant contributor to the financing requirements of the health system.

17. In one country the experience at the main hospital is instructive. In that institution the proportion of user fees actually collected is less than 5% of the value of the services provided. In another country after a long period of poor billing and collections the government embarked on a programme of strengthening the billing and collection system. However, although collections increased significantly in a short period, the concomitant overall increase in health care costs meant that the impact of user fees on the general expenses of the health sector continued to be very slight.

18. In order to advance the cause of health sector reform in the Caribbean it would seem that what is required is a different approach to the financing component of these reforms. In this context the policy responses required at this time for re-energizing the health sector reform efforts are similar to the steps listed in the search for a more relevant health financing system:

a) The first policy response would be is to paint a very clear picture of the health system which we would like to emerge in the future;
b) The second response would be to recognize the primacy of health financing reform in bringing about the behavioural changes which will make system reform possible; and
c) The third response will be to clarify the mechanisms by which the financing reforms will engineer the reforms in service delivery thereby spelling out the links between the financing system and the health status outcomes which are desired.

In this respect it is important to note that, the acceptability and efficacy of the entire reform process will depend on how the financing system is expected to deal with the four health security concerns of the population: access, quality, cost and equity.

19. In respect of the first response – the articulation of each country’s vision of its future health system – it is important to understand that many issues raised here are not technical. They are philosophical, and even political issues. Decisions, preferably consensual, will have to be made in respect of a number of questions:

a) What role is to be assigned to the private sector? A sharing of delivery and financing, or delivery alone? Moreover, what will be the regulatory role of the government in a shared system? Will the government be regulating its competitor? How will standards be determined? Will there be a role for associations of health professionals? Will there be a patient rights charter?
b) How will the health system deal with the poor? What will access mean? Access to what? By whom? Will user charges, fees or co-payments be part of the universal access mechanism? Where there are access barriers, how will they be removed?
c) How will the health system treat with the issues of cost and quality? How will the health information system be made into an instrument of cost containment and quality assurance?

20. The second response refers to the **primacy of health financing reforms**. What will be the dominant feature of these reforms? How will health services be predominantly financed in the future? Based on present evidence the answer to this question is no longer controversial. **The predominant health financing mechanism of the future must be one which addresses the development concern of health security.** In other words, the financing system must remove those health care uncertainties which have plagued the vast majority of our citizens in the past. There must be predictability in the overall flow of resources to the health sector, but more importantly, there must be predictability of access for individuals that need care. This points unambiguously in the direction of an **insurance mechanism.**

21. However, it cannot be a **private** insurance mechanism – at least not for basic services, including A&E, since private insurance operates for profit and is not concerned with access **per se.** Since private insurance premiums are determined on an individual basis these premiums are themselves a potential barrier to access. This probably one of the main reasons why for Caribbean health systems there seems to be enough justification for proceeding immediately to a **social insurance financing mechanism.** Since the bottom line of the financing system will be the **access to services** which it affords the population the movement to this mechanism has to be made in two steps.

22. For the first step countries will need to institute phased **national health insurance systems** thereby reducing earlier reliance on government revenues and out-of-pocket spending while having the means of accessing spending that already takes place in both the private and public sectors. In this scenario, user charges will probably feature only as an instrument of
utilization control and will certainly not be an important element in the overall financing of health services in the Caribbean.

23. The time has come for our governments to respond to the international evidence on out-of-pocket payments in general and on user charges, in particular. The sooner we phase out this particular access barrier the faster will we move to a situation where the health reforms will begin to impact on the health security and health status of the populations.

24. In suggesting that countries give primacy to the financing reforms we are in fact suggesting that these are the reforms which will create the incentive framework within which governments will be able to mobilise the popular and professional support needed to make the other administrative reforms follow the course mapped out to take us to the health system of the future. What is even more important is the fact that to the extent that equity and poverty alleviation remain dominant objectives of health sector reform there is no question that the health system must be reduce its reliance on user fees and private health insurance.

25. In this sense it can be argued that by giving preeminence to equity and poverty alleviation it is through the financing system that the health system is empowered to make an important contribution to the development of the Caribbean region. If, as we have argued earlier, population access to health services is a major determinant of equity and poverty alleviation, it becomes important that the health financing system be structured to maximize access.

26. The second step towards a social insurance financing system will be embodied in the attempt to define access in regional rather than national terms. The understanding will be that any serious commitment to expanding access for citizens of any country will necessarily involve coverage of services beyond national shores.

27. In other words, in this phase the attempt will be made to ensure that all Caribbean citizens will have similar access to basic health services, regardless of immediate residential status. The potential of such a system
is indeed tremendous. For one thing, it will give new meaning to a long-standing objective of Caribbean governments, namely the *sharing of services*. Moreover, it will do so in a manner which will not be subject to the inequities or the uncertainties of inter-country payments, since payments will not depend on the personal capacity of the patient involved or on the short-term fiscal position of the government in question.

28. While the first two policy responses discussed above require mainly the political will on the part of our governments to move away from a health system which cannot take us into the future with confidence, the third response - *linking the financing system to the population’s health* - requires urgent technical work to give flesh to the policy initiatives implicit in the first two steps. For what is at stake is the credibility and the efficacy of the entire reform process. Clearly one major implication here would be for every country to commit itself to instituting a modern health information system – not unlike the kind now used as a matter of course in the rest of our society today.

29. So far the basic message of our discussion is health sector reform needs to be explicitly focussed in the direction of improving the lot of the disadvantaged in our society. In other words, health sector reform has to be seen as part and parcel of our poverty alleviation effort and as part and parcel of the effort to improve the level of *equity* in the society. The proximate objective of the reforms must therefore be the expansion of access to the poor and the basic innovating mechanism will have to be a social insurance financing mechanism.

30. In order to better understand the role that health sector reform may play in the quest for equity and poverty alleviation it is useful to clarify the different components of the financing system. This is done in the diagram below.

31. The top row of the diagram portrays one categorization of the economic system. According to the diagram the system is made up of *factor markets*, *financial markets*, and *goods-and-services markets*. The workings of these three sets of markets leads to a range of income and
34. Turning to the last set of markets — the goods and services market — we find quite naturally that here is where final prices of health goods and services as well as other goods and services are determined.

35. Obviously the prices in the health sector are potential access barriers — be they the fees charged by private providers of health services or the user fees levied at public institutions. The higher these prices are, the more limited the population’s access.

36. What is not so obvious is the role that other prices play in the determining population access to health and services. There are at least two ways in which these prices operate as access barriers. They may represent (i) the prices of competing necessities — food, housing, clothing, for example; or (ii) the prices of goods complementary to health services — transportation, home maintenance, child care services. In other words, these are costs which will have to be incurred in any attempt to access health care.

37. Clearly, if the prices of competing necessities or access complements are high then access to health services, both public and private, will be accordingly diminished.

In a context where equity remains one of the important objectives of development, but where equity itself is not easily measured, it is useful, as Hall (1991) has indicated, to have easily identified barriers to access. In the diagram we portray a range of economically determined potential access barriers. No doubt it is the existence of these natural barriers which has hitherto justified the role of the government in seeking to expand population access to health services through the public sector health system.

38. What the diagram also shows, however, is that government expenditure is not without constraints. Such expenditure is anchored on a base of income taxes and expenditure taxes, which are themselves determined by household incomes and net sales revenues, respectively — proxies for national income in this framework.
39. From the present discussion there are two reform-related guidelines which emerge:

   a) In a system where access barriers appear almost as a matter of course, it becomes a development imperative that government expenditure should be a necessary component of the health financing system. This is the financing component that can act as a counter-vailing force in the determination of population access to health goods and services. A similar conclusion was arrived at by Donaldson and Gerard (1993) after a review of the empirical evidence on a number of countries:

   While public finance cannot ensure equity in principle......in the real world it is clear that publicly financed systems are likely to do better [than privately financed ones] in the pursuit of equity.

   b) The second guideline relates to government expenditure. The point here is that since government expenditure is constrained directly by its own revenues, in circumstances of economic stringency it becomes important that the effectiveness and the efficiency of such expenditure be increased above historically normal levels. Public sector reform is really about doing more with less, or doing better with what we have had in the past.

40. In other words, a properly functioning health financing system presupposes that government agencies operate in a manner which is not different from the constrained cost-minimizing behaviour which characterizes private firms and agencies. The constraints in this case will be a combination of equity and effectiveness criteria by which all expenditure plans will need to be guided.

41. The idea is that the positive contribution of health sector reform to the development objective will emerge from carrying out the operations of the public health sector under a new set of arrangements – arrangements that take cost, quality and equity seriously into consideration. We have already indicated that socio-economic development requires that these
arrangements be dominated by **equity** considerations – making universal access to a basic package of health services one of the main aims of public involvement in the health system.

42. The question which arises is whether government expenditure is the only means by which access barriers can be removed as we seek to give equity pride of place in our health sector reforms. As we have already suggested, it would make sense for the countries of the Caribbean to embrace social insurance as they seek to get their health systems to be more responsive to the needs of the populations. There is increasing evidence from a number of countries that **social insurance** is a non-private, non-government financing mechanism which can complement that work of public finance in health. This is especially true in the context of an equity-orientation which begins with the identification of a **basic package of health services**.

43. The social insurance mechanism combines **pre-payment** with the **pooling and sharing** of risk, and can be structured in a way to provide universal access to a basic package of services, thereby enhancing the health security of the entire population. It can also be structured to incorporate cost-containment and quality assurance in the delivery of health services.

44. In a society where the government has committed itself to guarantee access by the medically indigent there would be a close link between a social insurance health financing system and the level of public health expenditure. This would mean that together with government expenditure the social insurance mechanism will be an instrument of equity enhancement. Once the basic package of health services to which every citizen must have unrestricted access is identified, it is possible to develop the social insurance mechanism in a way which reinforces the role of public expenditure in expanding access.
45. In the diagram we have included both the social insurance mechanism and the Basic Package of health services which will be targeted by this mechanism and by public expenditure.

46. The identification of the benefit package of services to which each citizen must have ready access will then be the first step in reforming the health system with a distinct equity bias. It is a step which will enhance the health security of the population while giving health system managers a dynamic framework within which allocation decisions can be made and even revised.

47. The diagram shows that for the working and non-working population, access to the Basic Package will then come via the Social Insurance Fund. In the case of the working population the Fund will be built up from direct wage-based contributions and from any investment yields. For the non-working population the government will use a portion of its tax revenues to contribute premiums on their behalf.

48. The greater the extent to which personal health services are included in the Basic Package the more government expenditure will be available to provide health services which not only have high externalities, but which in the long run will serve to keep the overall cost of the health system down, i.e. health promotion, wellness programmes and disease prevention services.

Concluding Statement

49. In this presentation we have sought to make the case that

a) Financing reforms constitute the engine of the health reform process, with the embodied incentive system being the lubricant. These reforms should therefore take precedence over others including decentralization;

b) The preferred mode of financing the health system in middle and lower income countries is an insurance mode, and specifically, a social insurance mode. This is based on the assumption that the
maximization of effective access is a basic objective which derives from the equity and poverty-alleviation orientation of the health system;
c) Access to basic health services by all Caribbean citizens is the prime objective of the perennial call to a better sharing of services in the region and this can best be achieved by a regional health financing mechanism;
d) While an essential characteristic of the financing reforms would be the freedom of choice to access services either in the public or the private sector, the role of the government in making such access possible is pivotal to the health sector reform process;
e) The vision of a Caribbean health system driven by principles of access, quality, equity and cost efficiency is not only feasible but well within the economic and managerial capabilities of the region.

50. The challenge before us first and foremost is that we should have confidence in ourselves – confidence that we could set up and maintain a modern health financing system with the help of modern technology. Added to this is the challenge to our policy makers, namely to maintain enough flexibility so that we could quickly learn from our own experience as well as the experience of others.

51. While the task ahead is not a simple one, it is not one that we could turn away from. For what is at stake is the dignity of the people of the Caribbean region. As Eric Williams put it in 1969:

*If we succeed in the task which we have set ourselves we will be demonstrating in our own small way that the Caribbean countries can rise above their history of dependence, degradation, and self-contempt, and create worthwhile a societies, independent economies and self-respecting people.*