Universal Health Coverage Agenda in the Caribbean: Challenges and Options

TRT Experience

October 22nd 2012

If I were a politician

- Public Health care is free to everyone in Trinidad and Tobago and is paid for by the Government and taxpayers
- We have universal health care coverage even to visitors to our islands !!!

Qualifiers

- Health status eg disability adjusted life expectancy
- Responsiveness – speed of service, protection of privacy, and quality of amenities
- Fair financial contribution
- Ease of access
- Presence and extent of inequities

Personal Challenge

- ***What do we mean when we talk about Universal Health Coverage?***

- It involves judgements about who the potential recipients are, what is the range of services included within health care, and the quality of that care?

- Five main themes: accessibility to health care by its intended recipients, broad population coverage, a package of point-of-entry healthcare services, healthcare access based on rights and entitlements, and protection from the social and economic consequences of illness.
- The term Universal Health Care has most frequently been used in describing policies for care in high-income countries,
- Universal Health “Coverage” (UHC) has most often been applied to low- and middle-income countries;
- Hence the fact that population coverage may not guarantee a sufficient breadth of care services among the poorest countries (merely achieving basic coverage of the populace) is an important consideration that is often overlooked
- Some struggles on how we deal with this within our resources !!!

CHOGM 2009

Recognising the huge diversity in health needs across the Commonwealth, they agreed on a Commonwealth Health Compact, through which they:

- called on donor countries to deliver existing commitments for financing in health and identify ways to increase international resources;
- welcomed the steps taken by low-income countries towards universal access to health services, and making them free at the point of use and urged further concerted action;
- support the role of civil society to advocate for, support and contribute to universal coverage of basic health care.

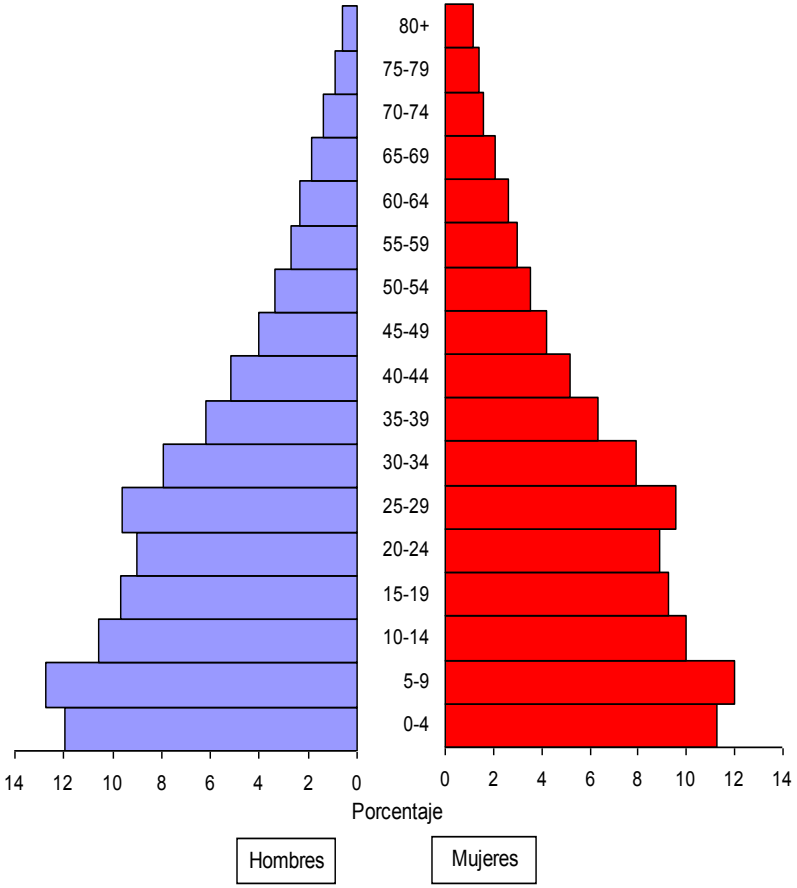
Males	Females	Total
665 119	659 580	1 324 699

M/F ratio 100.8

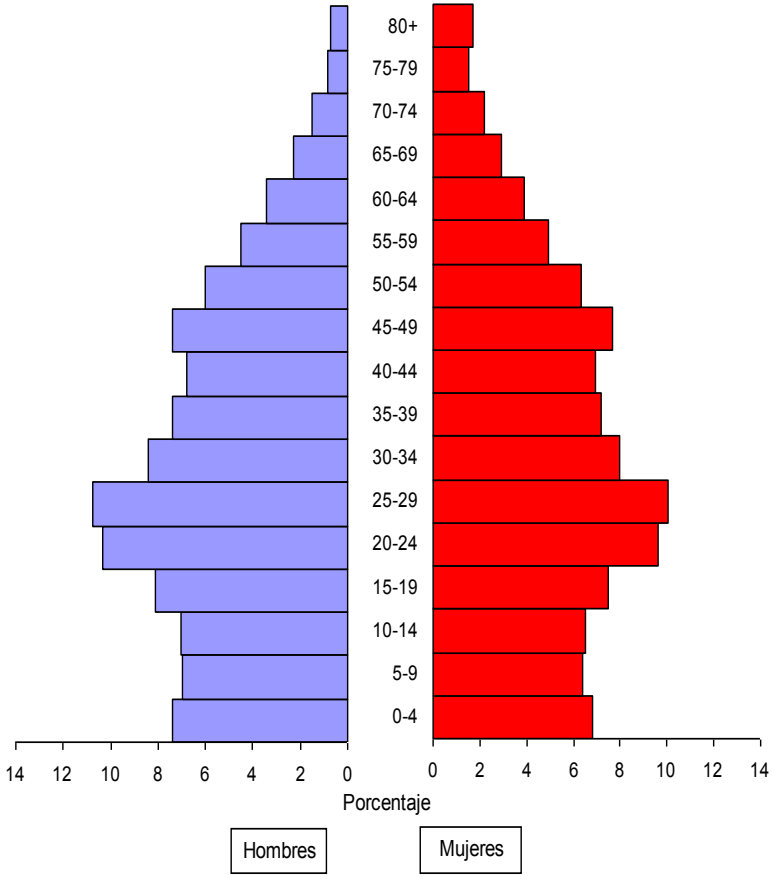
Trinidad	1 267 889
Tobago	56 810

Profile

1990



2010



Profile

Languages English (official), Caribbean Hindustani (a dialect of Hindi), French, Spanish, Chinese

Religions Roman Catholic 26%, Hindu 22.5%, Anglican 7.8%, Baptist 7.2%, Pentecostal 6.8%, Muslim 5.8%, Seventh Day Adventist 4%, other Christian 5.8%, other 10.8%, unspecified 1.4%, none

- **Population median age** 29.0 years (2006) **Population growth rate** 0.4% (
- **% of population living on less than $2 a day** 13.50% (2011)
- **Inequality of wealth distribution** *(Gini index)* 38.9 (1992)
- (0=perfect equality, 100=absolute inequality)
- **Total telephone subscribers as % of population** 163.07% (2010)
- (sum of fixed telephone lines and mobile cellular subscribers)
- **Internet users as % of total population** 48.5% (Data were released in 2011 and refer to 2010)
- **CO2 emissions** (Metric tons of CO2 per capita) 37.3275 (2008)

Indicators

Fertility Rate	1.6
Life Expectancy at Birth	70.2 (F -73.6) (M – 66.7)
IMR	13.1 per 1000
GDP % spent on health	6%
% health expenditure from public	58%
Heart disease, cancers, diabetes , cardiovascular diseases	> 60% deaths

LEADING HEALTH ISSUES AFFECTING DIFFERENT AGE GROUPS

TARGET GROUP	AGE	LEADING CAUSE OF MORBIDITY
Infants	<1yr	Infectious and parasitic diseases, ARI
Pre-school	1-5yrs	Infectious and parasitic diseases, ARI
School-age	5-14	External causes (injuries)
Young adults	15-24	External causes (injuries)
Adults	25-44	External causes (injuries)
Older adults	45-64	Diseases of the heart
Elderly	65 plus	Diseases of the heart

Health System Profile

- Multi-tiered system
- Public Largest Provider
- Private service delivery but publicly funded dialysis, cardiac, medical aid
- “Catastrophic” –Children’s Life Fund Authority
- Para-statal agencies (eg.Oil companies with own plans and facilities – retirees move beween

Human Resources for Health

- Shortages in key areas
- Importation from Cuba,Phillipines, Africa, India
- Staff Operating in both systems
- Varying contract arrangements for different specialists

Funding

- General taxation/Public purse
- Health surcharge
- Out of pocket
- Variety of insurances some as a part of employee benefits


Existing Hospitals
Psychiatric Hospitals
DISTRICT HEALTH FACILITY
ENHANCED HEALTH CENTRE
HEALTH CENTRE
OUTREACH CENTRE
Toco
Matelot
Blanchisseuse
Las Cuevas
Petit Valley
St. Ann's Hospital
Diego Martin
Maraval
Upper Laventille
Carenage
Woodbrook
Santa Cruz
San Juan
Aranguez
Oxford St
Morvant
St James
Port-of-Spain
El Socorro
St. James
George St
Laventille
Barataria
Oxford Street
Tunapuna
Caura
Arouca
Maloney
Arima
Tacarigua
La Horquetta
St Helena
El Socorro
Cunupia
Chaguanas
Chaguanas
Brasso Seco
Grande Riviere
Sans Souci
Cumana
Matura
Valencia
Sangre Grande
Cumuto
San Rafael
Las Lomas
Coryal
Manzanilla
Talparo
Carapichaima
Todds Road
Freeport
Flanagin Town
Biche
Couva
Gran Couva
Tabaquite
Brothers Road
Mayaro
Claxton Bay
San Fernando
Gasparillo
Marabella
Williamsville
South
Oropouche
Roy Joseph St
Ste Madeleine
Rio Claro
La Romaine
Princes Town
St Mary's
La Brea
Debe
Lengua
Indian Walk
Pt Fortin
Penal
Penal Rock Road
Fyzabad
Siparia
Guayaguayare
Chatham
Granville
Siparia
Cedros
Erin
Moruga

Tobago


Charlotteville
Bloody Bay
Castara
Les Coteaux
Parlatuvier
Speyside
Moriah
Mason Hall
Plymouth
Delaford
Roxborough
Bethel
Belle Garden
Pembroke
Canaan
Buccoo
H
Mt St George
Scarborough

Health Sector Reform Programme

- As far back as Julian report in 1957 talk of health sector reform
- Several components
- MoH as Policy and Regulatory and Regional Health Authorities as providers
- Rationalization of health services and infrastructure
- Development of a comprehensive financing strategy

Objectives of HSRP

(i) Strengthening policy development, planning and implementation capacities within the health sector,

(ii) separating the provision of services from financing and regulatory responsibilities,

(iii) shifting public health expenditure and influencing a similar shift in private sector spending to high priority health problems and cost-effective solutions;

(iv) establishing new administrative and employment structures which encourage accountability, increased autonomy, and appropriate incentives to improve productivity and efficiency;

and

(v) preventable morbidity and mortality through promoting lifestyle change and other social interventions

Challenges and Options & Report Card

- Role of MoH – still some difficulty with role definition. Many vertical services still under MoH
- New legislation to support regulation are works in progress – accreditation, radiation protection, laboratories, Health Servics Quality Act, Patients Charter, Patients Bill of Rights being drafted. etc
- Monitoring and Evaluation – approval to create a M & E unit obtained, staffing etc TBD

Challenges and Options & Report Card

- Health Financing – National Health Insurance still being contemplated, many models under evaluation. Strong lobby for increase in GDP %, efforts at increasing efficiency, minimizing wastage, rationalizing costs
- Costing of health services project almost completed.
- Health Information System (HIS)- unique ID, connectivity, EMR,

Social Participation

- Public Board meetings of RHAs
- Health Sector Quality Council
- Community Partnership Boards
- Funding support for NGOs and CBOs- DATT, Cancer Society, etc
- MoH website with blogs, client feedback system

Human Resources for Health

- Increased training especially nurses
- Manpower assessment currently in progress to be completed by January
- Several Hospitals about to start construction
- National Oncology Centre restart
- Therefore more critical needs for health personnel

Feedback

- Questions

- Thank You.