# VISION 2030 JAMAICA
# NATIONAL
# DEVELOPMENT PLAN

# DRAFT

# HEALTH SECTOR PLAN

**Prepared by:**

**The Health Sector Task Force**

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# VISION 2030 JAMAICA

# HEALTH

# SECTOR PLAN 2009 - 2030

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# 1. INTRODUCTION

Health is defined by the World Health Organization (WHO) as "a state of physical, psychological and spiritual wellbeing, and not merely an absence of diseases". Health, as a state and outcome, is impacted by the complex interaction of many variables: individual, social, biological (including genetic predisposition) and economic. The human capital perspective on health recognizes an initial endowment of health, which can be maintained, and enhanced by health production processes, including but not limited to health care and healthy lifestyles. An understanding that health, and not health care, is the intended outcome of a health care system is necessary in the planning of a health care system.

The Health Sector Plan presents the conceptual framework that will result in improvement in the health of every resident of Jamaica as well as the development of the Jamaican health care delivery system to that of first world standard by the year 2030. The sectoral Vision is *"Healthy lifestyles in a healthy environment producing healthy people"*. It will contribute to the achievement of Vision 2030 Jamaica, the National Development Plan (NDP), through National Outcome 1: *Healthy and Stable Population* which falls under Goal 1: *Jamaicans are empowered to achieve their fullest potential.* In this way, it will contribute to the fulfilment of the national vision – ***Jamaica, the place of choice to live, work, raise families and do business***.

The framework was developed by a national task force comprising members of civil society, state agencies/ministries, Non Governmental Organizations (NGOs), International Development Partners (IDPs) and members of academia and involved consultations and discussions among the group along with a

comprehensive two day retreat. This plan is one of 31 Sector Plans that will contribute to the achievement of Vision 2030 Jamaica.

The document is divided into two sections, section 1 contains the '***Overview'*** which provides a situational analysis of (a) the Jamaican health sector in terms of its service delivery mechanisms, policies and programs and (b) the efficacy of these mechanisms as reflected in the overall health status of the individual. Variables including age group, geographic location, socioeconomic status and gender will be used to complement the analysis where appropriate and where available data permits. The analysis of the individual's health status will be done using internationally accepted indicators and data provided by the Planning Institute of Jamaica (PIOJ) and the Ministry of Health and the Environment (MOHE). Discussions of private sector involvement in health service delivery and financing will be limited since hard data from the private sector are largely unavailable, due in part to the competitive nature of business and issues of confidentiality.

Section two of the document presents ***'The Road to 2030***' and reflects the outcome of the visioning process which will lead to a world-class health sector and health status comparable to the best standards in the world by 2030. The section presents a conceptual framework which is grounded in hard data and practical experiences from experts in the field and includes key priority areas for focus along with goals, objectives and strategies. The section focuses on the role of the state in this endeavour along with that of the individual, the private sector, NGOs and IDPs. The strategic approach takes into account gender, age group, socio economic issues, geographic location, Globalization, the Caribbean Single Market and Economy (CSME), and other external international and regional influences and their potential influences.

**SECTION 1**

# 2. SITUATIONAL ANALYSIS

## OVERVIEW

The Jamaican health sector is comprised of the public sector, which provides services to the majority of Jamaicans at the primary, secondary and tertiary levels at a highly subsidized cost (no user fees are charged) and the private sector which provides an alternative to the public sector and is largely the leader in the categories of new technological initiatives and health modalities.

Jamaica's ranking internationally may be linked to the country's performance against international benchmarks such as the Millennium Development Goals (MDGs). There are 8 Millennium Development Goals, 18 targets and 48 indicators. Three of the 8 MDGs are directly health related; one speaks to the eradication of poverty; one tackles primary education; one sustainable development and another global partnership for development. Based on the World Bank's classification, Jamaica could be called a "country in green"[1]. Countries in green are those countries that are on target to achieve the MDGs indicator targets within a specified time. They made progress in the 1990s fast enough to attain the indicator targets for selected variables such as primary enrolment, in the specified time period (by 2005 for gender equality and by 2015 for all others). They are "likely" to achieve the goals.

The MDGs relating to health are presented in Table A which provides a summary of targets, current status and recommendations

[1] http://www.developmentgoals.org/Achieving_the_Goals.htm

## TABLE A: Status of MDGs Relating to Health

| Millennium Goal | Target | Indicators | Status | Main Concern | Broad Recommendations |
|---|---|---|---|---|---|
| **4. Reduce child mortality** | Reduce the under-five mortality rate by two thirds between 1990 and 2015, | 1. Under-five mortality rate<br>2. Infant mortality rate<br>3. Proportion of 1 year old children immunized against measles | ***Far behind*** | Under-registration of births<br>No sustained policy action to reduce the rates | The under-registration of births and deaths needs special focus. |
| **5. Improve maternal health** | Reduce by three quarter, between 1990 and 2015, the under five mortality rate | 1. Maternal mortality<br>2. Proportion of births attended by skilled health personnel | ***Far behind*** | No sustained policy action to reduce the rates | Maternal deaths need to be accurately defined and registered |
| **6. Combat HIV/AIDS, malaria and other diseases** | Have halted by 2015 and begun to reverse the spread of HIV/AIDS | 1. HIV prevalence among the 15-24 year old pregnant women<br>Contraceptive prevalence rate<br>2. Number of children orphaned by HIV/AIDS | ***Lagging*** | Cultural context is a major hindrance to progress<br><br>Not prominent enough on the political agenda | Sustained political will is essential. The loss of productivity in the labour force is of immediate concern |
| | Have halted by 2015, and begun to | 1. Prevalence of death rates | | | |

| | | | | | |
|---|---|---|---|---|---|
| | reverse the incidence of malaria and other major diseases | associated with malaria<br>2. Proportion of population in malaria risk areas using effective malaria prevention and treatment measures<br>3. Prevalence of death rates associated with tuberculosis (TB)<br>4. Proportion of TB cases detected and cured under the DOTS (Directly Observed Treatment Short Course) | | | |

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As indicated in table A, Jamaica is lagging or far behind with respect to the MDG targets for the health indicators. This does not mean that our country has not achieved much in the area of health. In this regard, our average Life Expectancy of just over 72 years (2008 estimate) is comparable to many developed countries and far higher than the average of 65 for developing countries (see discussion below under "Health Status"). Similarly our disease profile has changed rapidly from one that was characterised by predominantly infectious diseases to one that is dominated by chronic, largely lifestyle illnesses, more in keeping with the profile of a developed country.

It must also be noted that Jamaica's epidemiological transition during the past century was achieved at considerably less cost for each gain made than was achieved in many developed countries. This has resulted in Jamaica being rated by the World Health Organization as having a highly efficient health service (defined in terms of health status per unit cost).

**Table B: Regional Comparisons using select Indicators**

| Country | Infant Mortality Rate (IMR)/1,000 Live Births | Life Expectancy M/F | Births/1,000 women aged 15-19 | Contraceptive Prevalence (any method) | HIV Prevalence Rate % (15-49 Years) M/F | Maternal Mortality Rate (MMR) |
|---|---|---|---|---|---|---|
| **Bahamas** | 12 | 68.7/75.0 | 58 | 62 | 2.6/4.0 | 60 |
| **Barbados** | 10 | 72.9/79.1 | 42 | 55 | 2.3/0.8 | 95 |
| **Cuba** | 5 | 76.7/80.2 | 50 | 73 | 0.1/0.1 | 33 |
| **Haiti** | 57 | 52.6/53.8 | 58 | 28 | 3.5/4.1 | 680 |
| **Jamaica** | 14[2] | 69.3/72.7 | 74 | 66 | 2.2/0.8 | 87 |
| **Trinidad and Tobago (T&T)** | 13 | 67.5/72.5 | 34 | 38 | 2.3/3.0 | 25 |

Source: State of the World Population 2007, UNFPA

[2] By the National estimates, the rate for Jamaica is 19.9/1000 but in order to have standardised figures for comparison, the UNFPA figure is used for this table.

Table B (above) provides a comparison, between the health status and behaviour of our people as measured by select indices, and some other Caribbean Countries which have achieved the best results in our region with respect to these indices. Jamaica's births per 1 000 women (15- 19 years) were higher than all the other countries in Table B but the Infant Mortality Rate (IMR) compared well with these same countries with the exception of Cuba. Cuba's IMR compares with that of a developed country (5/1 000). Jamaica's Maternal Mortality Rate (MMR) also compared favourably with countries such as Barbados and Haiti but lagged far behind Trinidad, which had by far, the lowest MMR among this group of countries, and Cuba, which had the second lowest in the region (25 and 33 respectively). The Cuban Health care system has been internationally recognised as highly efficient given that country's low HIV prevalence, IMR and MMR and high Life Expectancy (LE) which is on par with developed country standard (as is Barbados's LE).

The UNFPA State of the World Population Report 2007 indicates that Jamaica's expenditure on Health as a percentage of GDP was 2.7 per cent compared with 6.3 per cent or Cuba, 2.9 per cent for Haiti and 1.5 per cent for Trinidad &Tobago. These expenditures must be understood against the background of the total estimated population which was 11.3 million for Cuba, 8.8 million for Haiti, 2.7 million for Jamaica and 1.3 million for Trinidad &Tobago. The estimated expenditure on health for Bahamas and Barbados were not available.

**HEALTH STATUS**

Jamaica ranks high among developing countries in the world on human development and the health of Jamaicans has improved considerably during the 20th century. Life expectancy at birth increased from 38 years in 1 900 to just over 72 years in 2008 while the infant mortality rate declined from 174.3 deaths per 1 000 live births to 19.9/1 000 live births over the same period[3]. By these achievements the Human Development Index, has ranked us above the average with respect to indices such as life expectancy which stands at 65.0 years for developing countries. The National estimate FOR MMR

[3] The UNFPA estimates are lower. As earlier shown on Table B, the UNFPA estimate for 2007 was 14.

was 106.2 per 100 000 in 2006 (this is higher than the UNFPA State of the World Population 2007 estimate of 87 shown in Table B). The crude birth rate was 17.0 per 1 000 mean population. Total fertility rate for the same year stood at 2.5 /1 000 women in the 15 – 49 years age group. Immunization coverage for the major vaccines on the government's immunization schedule were; for DPT, OPV, BCG for children 0-11 months, 87 per cent; and MMR, for children 12- 23 months, 87.2 per cent.

The leading causes of death during the first half of the 20th century were infectious diseases. Since the latter half, the main causes of mortality and morbidity are now the chronic non-communicable lifestyle diseases, injuries and mental illness (see Table C[4] below).

**TABLE C:**

**CURATIVE VISITS TO PRIMARY HEALTH CARE FACILITIES BY LEADING CONDITIONS AND REGION, PUBLIC HEALTH SECTOR, 2008 (Jan- Sep)**

| DIAGNOSIS | Jamaica | SERHA | NERHA | WRHA | SRHA[5] | |
|---|---|---|---|---|---|---|
| | No. Visits | No. Visits | No. Visits | No. Visits | No. Visits | % of top 6 visits |
| Hypertension | 104 565 | 39 412 | 18 260 | 21 488 | 25 405 | 22.9 |
| Diseases of the Respiratory Tract | 111 093 | 59 709 | 16 955 | 12 169 | 22 260 | 24.3 |
| Skin Disease | 83 247 | 38 691 | 14 955 | 12 658 | 16 943 | 18.2 |
| Genito- Urinary Diseases (including STD) | 76 631 | 45 252 | 9 114 | 9 782 | 12 483 | 16.8 |
| Musculoskeletal | 45 127 | 17 164 | 9 404 | 8 336 | 10 223 | 10.0 |
| Psychiatry | 35 818 | 17 525 | 5 172 | 6 848 | 6 271 | 7.8 |
| **TOTAL** | **456 481** | **217 753** | **73 860** | **71 281** | **93 585** | **100.0** |

[4] Economic and Social Survey, Jamaica, 2008.

[5] SERA =South East Regional Health Authority; NERHA = North East Regional Health Authority; WRHA = Western Regional Health Authority; SRHA= Southern Regional Health Authority.

Table D presents trend data on some key indicators of utilization of acute secondary care facilities in the public health sector over the period 2004 to 2008.

| TABLE D: | | | | | |
|---|---|---|---|---|---|
| **INDICATORS OF UTILIZATION OF ACUTE SECONDARY CARE** | | | | | |
| **FACILITIES IN THE PUBLIC HEALTH SECTOR, 2004-2008** | | | | | |
| | | | | | |
| **INDICATOR** | **2004** | **2005** | **2006** | **2007** | **2008** |
| Mean Bed Complement | 4 277 | 4 629 | 4 846 | 4 207 | 3 896 |
| In-patient Discharges | 179 418 | 174 218 | 172 697 | 147 775 | 190 505 |
| Bed Occupancy (%) | 73.3 | 54.6 | 56.6 | 60.9 | 72.3 |
| Average Length of Stay (days) | 6.8 | 5.6 | 5.7 | 5.6 | 5.5 |
| Annual Turnover Rate (mean %) | 41.9 | 37.3 | 35.6 | 34.7 | 48.4 |
| Rate Per 100 Discharges | 4.0 | 4.3 | 3.8 | 3.8 | 3.8 |
| Deliveries | 41 554 | 42 620 | 39 352 | 31 894 | 40 174 |
| Out-Patient Visits | 504 059 | 477 198 | 481 829 | 403 331 | 554 400 |
| Casualty Attendance | 765 835 | 680 898 | 715 707 | 627 578 | 864 044 |
| Pharmacy (patients seen) | 518 491 | 492 083 | 514 095 | 461 759 | 684 909 |
| Pharmacy items dispensed | 1 068 741 | 1 101 927 | 1 167 287 | 1 123 033 | 1 757 589 |
| *Source: Source: Economic and Social Survey Jamaica, 2008* | | | | | |

The data reveal marked increases in the utilization of the public facilities after 2007, but no corresponding increases in the capacity of the facilities. For example, the mean bed complement declined from 4 207 in 2007 to 3 896 in 2008 but the casualty attendance rose from 627 578 to 864 044 over the same period (an increase of approximately 38 %). However, the data also show a notable increase in the number of discharges over the same period. (up from 147 775 to 190 505 – a 29 %). This would provide some balance to the increased intake.

## DETERMINANTS OF HEALTH

Determinants of health are conditions which predispose an individual to ill health. These conditions range from physiological differences in make-up to the geographic residence of an individual. There is also the category of social determinants, which is a relatively new concept and examines those social and economic conditions that impact on health. Some of the main determinants of health are discussed below.

### *Gender*

Men and women have different needs and gender sensitive strategies must ensure fairness in the distribution of benefits and responsibilities. Strategies to eliminate gender imbalances are necessary to achieve equitable outcomes across gender.

The differences in the health status of males versus females are evident in a number of areas. For example, there are differences in the health seeking behaviour of each gender, where, males are more reluctant to seek care and tend to seek care much later when their illnesses are usually at a severe stage[6]. Chronic illnesses such as diabetes, hypertension, arthritis and asthma are reportedly higher among females than males. Males tend to be more prone to "violence-related injuries" (VRIs) and injuries from motor vehicle accidents (MVAs) than females[7].

### *Demographic Transition*

The population in Jamaica was estimated at just over 2.6 million in 2007 with an annual growth rate of 0.5 per cent. Total fertility rate was reported as being 2.5 children per woman. There were 17.0 births and 6.4 deaths per 1 000 population respectively[8]. The basic population structure has undergone gradual change over the past 10 years, with the pyramid still showing a large but diminishing base, a growing middle and a widening peak. This has resulted from a gradually decreasing proportion of those in the under 25 year age group, increases in the working age group (15 - 64 years) and increases in the elderly population. Distribution of the population by parish for the

[6] Jamaica Survey of Living conditions, 2002, 2004.
[7] Economic and Social Survey, Jamaica, 2005.
[8] Economic and Social Survey, Jamaica, 2007.

period 2003-2007 showed that Kingston and St. Andrew had the largest proportion of the population (24.7%). St. Catherine had the second largest proportion (18.5%), while Hanover had the lowest (2.6 %)[9].

There are some health conditions that affect a particular age group more than others. Asthma, for example, is more prevalent in children, while chronic illnesses are more prevalent in the older age group, more so, the elderly[10]. The prevalence of some health conditions vary according to the geographic location of the residents. For example HIV/AIDS is more prevalent in some parishes than others, usually those with high involvement in the tourism industry, such as St. James and St. Ann[11]. Additionally, persons living in the Rural Area reported a higher level of illness in 2004 when compared with persons in the KMA and Other Towns[12].

***Social Determinants***

Social determinants of health are conditions, economic and social, under which people live that influence the state of their health. The concept grew out of the search by researchers to identify the specific exposures by which members of different socio-economic groups come to experience varying degrees of health and illness. Almost all major diseases are determined to some extent by a network of interacting exposures that increase or decrease the risk for the disease and these conditions are a result of social, economic and political forces. Examples of social determinants as compiled by the Public Health Agency of Canada are:

1. Income and social status
2. Social support networks
3. Education and health literacy
4. Employment and work conditions
5. Social environments

[9] Economic and Social Survey, Jamaica, 2007.
[10] Jamaica Survey of Living conditions, 2002, 2004.

[11] Economic and Social Survey, Jamaica, 2004.
[12] Jamaica Survey of Living conditions, 2002, 2004.

6. Physical environments
7. Gender
8. Culture
9. Availability of health services
10. Personal health practices and coping skills (including lifestyle practices such as smoking, alcohol consumption and condom use.)

There is also a "Social Determinants of Health" (SDOH) national conference list which is unique in that it specifically focuses on the public policy environment (e.g. income distribution) rather than only characteristics associated with individuals (such as personal income and social status). These SDOH are:

1. Aboriginal status
2. Early life experience
3. Education
4. Employment and working conditions
5. Food security
6. Gender
7. Health care services
8. Housing
9. Income and its distribution
10. Social safety net
11. Social Exclusion
12. Unemployment and employment security

Based on a UNESCO estimate for 2004, the Jamaican adult literacy rate was 86.0 per cent. Approximately 77.3 per cent of our population had access to safe water in 2006 and 100.0 per cent had access to adequate sanitary disposal facilities in the same period. The total Labour force participation rate was 65.4 per cent in 2008, (73.8 per cent for males and 57.5 per cent for females[13]). The prevalence of poverty in Jamaica was 14.3

[13] Economic and Social Survey, Jamaica, 2008.

percent in 2006 declining by 11.8 percentage points from 1996[14]. The rate declined further to 9.9 per cent in 2007, but it is suspected that the impact of the Global recession on Jamaica will in the short run have a negative impact on the prevalence of poverty. The Gross Domestic Product per capita was J$389 100 in 2008 (J$187 900 at constant prices).

There are no significant barriers that may prevent physical access to basic public health services as the country has a well developed network of health centres and hospitals and payment barriers, in principle, have been eliminated by the abolition of user fees by the Government. However, the level and quality of facilities, and service delivery are unequal across the country. Women have access to education and job opportunities, but the majority of the poor are women and children. The unemployment rate was 10.6% in 2008, with the unemployment rate for males being 7.3 per cent and 14.6 per cent for females.

The ability of persons to afford health care has always been a major concern for policy makers and providers of health care services. While the cost for private sector services is hardly disputed, the cost for services provided by the state has at times met with criticisms. The introduction of user fees over the previous decade served to compound the problem and led to questions about its likely negative impact on the health seeking behaviour of persons and ultimately their health status. Data from the 2004 Jamaica Survey of living Conditions reveal that the reason why some 19.0 per cent of persons who needed care in 2004 did not seek it was that they could not afford it. This was against the background that the average expenditure by users on care in the public sector was J$489.40 compared with J$2 278.00 in the private sector[15]. The removal of user fees for health care in the public sector since 2008 has removed this barrier and has resulted in increased demand for public health services. This initially led to shortages of some supplies such as pharmaceuticals and medication. However, steps have since been taken and are continuing to better balance the supplies with demand.

[14] Jamaica Survey of Living conditions 2006.
[15] Ibid.

## EPIDEMIOLOGICAL TRANSITION

As earlier indicated (Table C, p.12), the epidemiological profile of the population is linked to their lifestyles, particularly among the urban population. It is not known what effect the increased availability of processed foods has had on nutritional status but the proportion of energy obtained from fat is on the increase. The rate of teenage pregnancy per population declined, but the total numbers increased. A large share of illness is due to intentional and unintentional injuries. Injuries from violence are at epidemic proportions and this may be seen in the number of murders committed annually. In the last decade they have averaged more than 1 000 per annum. In 2008, the rate was estimated at 60/100 000 of the population[16].

Hypertension and diabetes account for a great share of the morbidity and mortality, in particular, among smokers. A Healthy Lifestyle survey[17] showed that 51 per cent of people had used tobacco in the previous month. In 1993, 79 per cent of men and 41 per cent of women reported drinking alcohol. Its consumption was identified as a factor in the increasing incidence of traffic accidents. A 1993 lifestyle survey also found that 38 per cent of men and 10 per cent of women aged 15-49 years had smoked marijuana. Cocaine was reportedly used by 2 per cent of males and by less than 1 per cent of women.

Specific projects aimed at lifestyle awareness and promoting physical activities have been developed in schools. The Ministry of Health and the Environment also has begun to move aggressively by firstly declaring a no smoking policy in all its buildings.

## THE POLICY AND REGULATORY FRAMEWORK

During the 1980s and 1990s, health-care systems, particularly in sub-Saharan Africa, were collapsing[18], multiple pressures, including deteriorating economic conditions, demographic transitions, HIV/AIDS, and other emerging or re-emerging diseases, were too much of a burden on already strained health-care systems. Health sector reform, the

[16] Economic and Social Survey Jamaica, 2008.
[17] J. Figueroa, E.Ward et al, 2005
[18] Simms et al. 2001; Tursheh 1999.

new imperative, encompassed a range of strategies aimed at improving the financing, organizing and delivery of health services. The World Bank in particular, offered a number of policy ideas to mobilize resources and improve the efficiency of the systems.

Proposed as a cure for economic woes, Macroeconomic Adjustment Policies (MAPs) allowed international lenders to support a country's balance of payments on the condition that certain economic policy interventions were undertaken. These may be divided into two main types. The first were measures, typically guided by the IMF, to correct for internal and external macroeconomic disequilibria over the short term and were aimed at contracting demand, principally through restricting public expenditure. Once an economy had stabilized, policies could then be implemented to address structural barriers to production[19]. This involved medium- to long-term measures for stimulating economic growth. These "supply" policies relied on a variety of directions recommended by the World Bank that included, among others, liberalization, privatization, and deregulation. MAPs varied with respect to their content, scope, intensity, duration, and ultimate outcomes, leading authors to propose different approaches to classifying MAPs and the countries adopting them, for purposes of comparison.

Most countries that underwent MAPs during the 1980s and 1990s also initiated health sector reform. Sometimes these reforms were stimulated by problems relating to the economy, or by specific causes within the health sector, or combinations of both. Financial crises in the public sector led to severe consequences, such as deterioration of public health infrastructure, quality of health services, and declining capacities of governments to provide free health care for their citizens. Policies shaping the organization and delivery of quality health services were inadequate, focusing largely on curative care within hospital settings.

Health sector reforms have adopted different approaches and have been varied with respect to content, timing, and implementation. Generally, these reforms were aimed at increasing health sector financing; reallocating public budgets to promote primary health-care services; reorienting public funds to benefit the poor; improving the quality

[19] Husain 1994.

and range of services; increasing utilization; decentralizing the public sector through institutional reforms; reinforcing managerial capacities; and liberalizing the health sector by expanding private sector involvement[20].

The central government has traditionally provided most medical services in Jamaica through the Ministry of Health and the Environment (MOHE). The National Health Services Act of 1997 authorized the decentralization of the health care system through the creation of regional health authorities and the restructuring of the MOHE. In 1996, the island had 364 government-operated primary health centres offering five levels of service, 23 public hospitals and nine small private hospitals. In 1995 there were 417 doctors and 1,836 registered nurses. As of 1999, there were an estimated 1.4 physicians and 2.1 hospital beds per 1 000 people. Total health care expenditure was estimated at 5.5 per cent of GDP.

The health sector reform (HSR) initiative and specifically the decentralization of the public sector, rationalized the roles and functions of the public health sector giving the MOHE Head Office a policy making, steering and regulatory role while the Regional Health Authorities (RHAs) have the leading responsibility for managing the public health care networks and the delivery of services. The health sector reforms were designed to bring the responsibility for health care closer to the point of service delivery.

## FACILITATING HEALTH FOR ALL

Various measures have been adopted to try and ensure that access to health care is available particularly to the most vulnerable members of our society. In the wider sense these measures are not limited to the health sector and are referred to as safety nets. Safety nets consist of a network of benefits and services designed to assist the poor or vulnerable to achieve and maintain satisfactory living standards. Within the health sector, various mechanisms exist to assist these groups including the National Health

[20] Gilson and Mills 1995.

Fund (NHF), the Jamaica Drug for the Elderly Programme (JADEP), the Drug Serv programme, NI Gold, and the removal of user fees for using public health facilities.

The National Health Fund/ Jamaica Drugs for the Elderly Programme (NHF/JADEP) provide three categories of benefits and services namely: individual; institutional; and public Information/Promotional services. Individual Benefits are in the form of direct assistance provided to persons through the NHF and JADEP. The NHF provides a subsidy for over 800 specific prescription drugs while JADEP provides 72 drugs, free of charge to persons over 60 years of age, suffering from any of 10 chronic illnesses. Institutional Benefits are in the form of financial support provided to both public and private sector projects aimed at improving the delivery of health care services.

The Drug Serv programme provides affordable pharmaceuticals to Jamaicans thereby influencing the prices in the private sector market. Consequently, there has been a decrease in the price differential between pharmaceuticals obtained under the Drug Serv programme and those supplied by other pharmacies. This programme is managed by the Health Corporation Limited (HCL) which has been the major supplier of pharmaceuticals and medical supplies to the public health sector for 12 years. Through its outreach programmes, the HCL has supported and promoted healthy lifestyles by hosting health fairs and health talks in schools and the workplace.

The NI gold was introduced by the National Insurance Scheme (NIS) in an attempt to better address the needs of pensioners and is a supplemental health insurance benefit available to all NIS pensioners administered by Blue Cross of Jamaica.

## NEW TRENDS IN PUBLIC HEALTH

### *Complementary and Alternative Medicine*

Complementary and alternative medicine (CAM) and traditional medicine (TM) play a role in public health in both developed and developing countries. CAM describes deliberately chosen alternatives to Western medicine by people who have access to the latter, while TM refers to practices that are used and spread by indigenous people.

In affluent countries, people select CAM according to their specific beliefs, with many more Europeans than Americans using homeopathy, for example. As many as 60 per cent of those living in France, Germany, and the United Kingdom consume homeopathic or herbal products. Only 1 to 2 per cent of Americans use homeopathy, but 10 per cent of adults use herbal medicines, 8 per cent visit chiropractors, and 1 to 2 per cent undergo acupuncture every year[21]. Use of CAM and TM among patients with chronic, painful, debilitating, or fatal conditions, such as HIV/AIDS and cancer, is far higher, ranging from 50 to 90 per cent[22] in the USA.

There is little scientific evidence that CAM techniques are safe and effective; however, some studies have shown the efficacy of treatments such as acupuncture and herbal extracts commonly used in pharmaceuticals. Some countries have begun to incorporate CAM into health care plans and to regulate its products and practitioners.

In many developing countries, TM is the sole source of health care for all but the privileged few. Contrary to popular belief, however, TM is not always cheaper than conventional medical care, and in some cases, is significantly more expensive. Nonetheless, the expanded use of TM could, in some instances, yield health, social, and economic benefits. In countries where local pharmacies are the primary source of treatment for many ailments, improving the quality of TM might serve as an effective substitute for allowing the unregulated use of conventional modern medical treatments. Training traditional healers is substantially less expensive than training doctors and nurses. Traditional healers can be recruited into a more broad–based system for delivering public health, serving as primary health care workers and providing advice on sexually transmitted diseases, oral rehydration therapy, and other matters.

The objective of medicine is to address people's unavoidable needs for emotional and physical healing. The discipline has evolved over millennia, drawing on the religious beliefs and social structures of numerous indigenous peoples, to exploit natural products in their environments, and more recently by developing and validating therapeutic and preventive approaches using the scientific method. Public health and

[21] Ni, Simile, and Hardy, 2007.
[22] Richardson and Straus, 2002.

medical practices have now advanced to a point at which people can anticipate—and even feel entitled to—lives that are longer and of better quality than ever before in human history.

Yet, despite the pervasiveness, power, and promise of contemporary medical science, large segments of humanity either cannot access its benefits or choose not to do so. More than 80 per cent of people in developing nations can barely afford the most basic medical procedures, drugs, and vaccines. In the industrial nations, a surprisingly large proportion of people opt for practices and products for which proof of their safety and efficacy is modest at best, practices that in the aggregate are known CAM or TM.

There is remarkably little correlation between the use of CAM and TM approaches and scientific evidence that they are safe or effective. For many CAM and TM practices, the only evidence of their safety and efficacy is embodied in folklore. Beginning more than 1 500 years ago, data on the use of thousands of natural products were assembled into impressive monographs in China, India, and Korea, but these compendiums—and similar texts from Arabic, Egyptian, Greek, and Persian sources and their major European derivatives—are merely catalogues of products and their use rather than formal analyses of safety and efficacy.

The cumulative data on the pharmacological and potential adverse effects of herbal supplements now dictate that patients discuss their use of supplements with knowledgeable practitioners before initiating treatment.

As to evidence of the efficacy of CAM and TM approaches, thousands of small studies and case series have been reported over the past 50 years. Few were rigorous enough to be at all compelling, but they are sufficient to generate hypotheses that are now being tested in robust clinical trials. The existing body of data already shows that some approaches are useless, that for many the evidence is positive but weak, and that a few are highly encouraging.

## THE PUBLIC HEALTH SECTOR- THE INSTITUTIONAL FRAMEWORK

The public sector is comprised of the Ministry of Health and the Environment, its agencies and departments, a network of 23 public hospitals, approximately 350 primary health care institutions and the University Hospital of the West Indies and Medical School.

The institutional basis for a comprehensive public health service was developed in the 1960's and 1970's with the building of a network of health centres islandwide and the development, in 1970, of an outstanding model of primary health care that contributed to the vision of health for all by the year 2000 articulated in the WHO Alma Ata Declaration of 1978. Features of the primary health care system included multidisciplinary health teams at parish levels and active community participation in health.

There are three main layers to the delivery of care in the public health sector, namely; primary care, which essentially represents the first line of contact with the client and the health care delivery system. Primary care facilities include all health centres island wide. Patients are assessed and appropriately referred to the next layer of the health care system depending on the nature of care that they require. The next layer of the delivery scheme is the secondary level facilities which include the island's hospitals (except the advanced specialist hospitals). Patients requiring admissions and/or surgical procedures and overall advanced level of care are handled at this level. The third layer is the tertiary level, and this involves highly specialized services. These centres are also used as training institutions for the island's medical professionals.

The current organizational arrangement of health care delivery within the public sector is mainly via hospitals and health centres distributed across the various health regions. Hospital services[23] in the public sector are provided through general and specialist facilities. These are administered through the boards of the four Regional Health

[23] http://www.moh.gov.jm.

Authorities. Hospitals are classified as A, B or C according to the level of service and the size of the population served.

Type C Hospitals are basic district hospitals. In-patient and out-patient services are provided in general medicine, surgery, child and maternity care. Basic x-ray and laboratory services are usually available.

Type B Hospitals are situated in the larger urban centres. They provide in-patient and out-patient services in the four basic specialties: general surgery, internal medicine, obstetrics and gynaecology and paediatrics.

Type A Hospitals are multi-disciplinary. They are the final referral points for secondary and tertiary services. The Kingston Public Hospital and the Cornwall Regional Hospital are examples of such institutions.

There are 10 dental, two family planning clinics and a total of 322 health centres island wide.

Table E below shows the distribution of health centres and hospitals within the regional health authorities.

| TABLE E: | | | | | | |
|---|---|---|---|---|---|---|
| **NETWORK OF SERVICES DELIVERY FACILITIES, 2006** | | | | | | |
| **REGIONAL HEALTH AUTHORITIES** | **PARISHES** | **FACILITIES** | | **POPULATION SERVED** | **ADMISSIONS PER 1000 POPULATION** | **DISCHARGES PER 1 000 POPULATION** |
| | | **Health Centres** | **Hospitals** | | | |
| South East Region | Kingston, St. Andrew, St. Thomas, St. Catherine | 90 | 9 | 1 233 076 | 69.8 | 69.3 |
| North East Region | Portland, St. Mary, St. Ann | 82 | 4 | 363 215 | 65.8 | 65.5 |
| Western Region | Trelawny, St. James, Hanover, Westmoreland | 82 | 4 | 385 560 | 84.6 | 84.5 |
| Southern Region | St. Elizabeth, Manchester, Clarendon | 94 | 5 | 577 975 | 55.7 | 56.1 |
| | | | | | | |
| **TOTAL** | | **348** | **22** | **2 559 826** | | |
| Source: Ministry of Health | | | | | | |

The Ministry of Health was preparing a framework for a renewed primary health care strategy and has earmarked funding for the first phase. This framework is necessary to promote sustainability, quality and cost effectiveness given the changing health landscape. The focus includes four strategic areas namely: Strengthening leadership, the information system, health financing and human resources.

**FINANCING**

The Public Health sector is financed primarily from Government of Jamaica (GOJ) budgetary allocations. These allocations are supplemented by inputs from Non-

Government Organizations (NGOs), and International Development Partners (IDPs). This section examines inputs from these sources to the sector and makes comparisons with previous periods as appropriate.

Financing health service delivery is a major challenge. The abolition of user fees has increased demand on the resources of the public health care system and this has been exacerbated by existing human resource constraints. Government estimates the financial resource gap to be about 30 per cent of requirements. Data on the actual delivery costs and performance needs to be strengthened. The Ministry of Finance and the Public Service (MFPS) largely determines the budget and controls the cash flow, although the MOHE and RHAs have a significant degree of autonomy.

*Budget 2008/2009*

The Recurrent Budget for the fiscal year 2008/2009 was projected at J$21.9B while the Ministry of Finance established a budget ceiling of J$21B. However, the actual allocation for the fiscal year was estimated at J$26.7 Billion. In the face of the current recession, it is likely that there will be budget cuts in the 2009/10 fiscal year.

*Impact of Abolition of User Fees*

The abolition of user fees as of April 1, 2008 is estimated to have resulted in forgone user fees of J$1.74B. The implementation of the abolition of user Fees for children under 18 years old accounted for an estimated J$526M. The implications are that an additional J$1.21B will be needed from the Ministry of Finance and the Public Service (MFPS). This does not include any increase in the cost of providing services attributable to the increase in utilization associated with the abolition of user fees.[24]

*Project Funding by the National Health Fund (NHF)*

The (NHF) was created in 2003 in response to the need for a public Fund to finance the improvement of health care delivery. The NHF is financed by a one per cent payroll

[24] Bustamante Hospital for Children experienced a 30 – 40 per cent increase in utilization, while some general hospitals gave anecdotal reports of up to 70 per cent increase in their A&E services, after implementation of abolition of fees for children under 18 yrs.

tax, 23 per cent tobacco consumption levy and a five per cent share of the special consumption tax on petroleum, alcohol and tobacco products, and represents Phase 1 of a National Health Insurance Plan. The NHF provides institutional funding to public and private entities for health projects, as well as individual benefits for the purchase of medication.

The NHF budget for Institutional Benefits was J$500M for the fiscal year 2007/2008. With the constant inflow of new beneficiaries to the NHF the cost of Individual Benefits is projected to increase year on year. In light of this, the NHF will not be able to fund new projects for the Ministry unless its revenue is substantially increased.

Revenue has declined by at least J$600M per annum since the Cigarette Company moved their manufacturing operations to Trinidad and Tobago. A new revenue measure must be approved for the NHF for the coming fiscal year or the Ministry will be unable to secure additional project funding and the NHF may begin to face some financial challenges. This challenge is looming at the juncture where significant financial outlay is required to transform the health sector.

Insurance coverage in the public sector is based on the British National Health Service model where health is considered a public good and government provides care at little cost. There is also the private health insurance model, which covers about 10 per cent of the population. Private health insurance is loosely regulated. The level of detail, reliability and timeliness of information on the financing of health care needs to be improved. Information on the financing and performance of the private sector is not collected.

***The Private Sector***

The private health sector provides health insurance, financing, pharmaceutical and health care delivery services. Little information is available on the organization, operations and other characteristics of the private health sector and there is very little reporting to the Ministry. Currently, the private health sector is largely unregulated; although sector reform plans call for the MOHE to develop more regulatory control

over the entire health system in the future. There is little formal relationships between the public networks and the private sector. Sector reform seeks to promote public private partnerships in a number of areas such as hospital care, pharmaceutical and diagnostic services. There are about eight private hospitals and 2 000 practicing physicians. A significant proportion of the ambulatory and primary care is delivered in the private sector. The private hospital sector only handles about 5 per cent of the total hospital services with the public hospitals handling the most complicated and costly cases, particularly for patients who are poor and those who are not insured.

The private sector's involvement in the provision of health care services cannot be ignored, and while data from that sector are largely unavailable, inconsistent and unstandardised, the contribution of the private sector, especially as regards the introduction of new and cutting edge technology, is significant. The private sector has via this avenue, contributed to the development of the overall health sector in Jamaica. The introduction of imaging tools such as Computerized Axial Technology (CAT) Scan, and Magnetic Resonance Imaging (MRI), as well as specialized laser and cardiac surgeries and other state of the art surgical operations were largely first introduced and practiced on a wide scale in the private health sector.

The inherent problems facing the providers of private health care are the lack of resources for hospital in-patient care in most cases, compounded by the inability of patients to pay for these services once they are established. These providers have long called for some type of national health insurance to help offset the cost for services and in so doing allow more Jamaicans to access these state of the art services. It should be noted that while many of these life saving technology are offered in the public sector, availability is limited and patients often have to wait a long time for an appointment.

In recent times, however, more attempts have been made to both subsidize some of the services within the public sector to private users and also to offer tax relief to private service providers who invest heavily in the provision of health care services. This type of practice has to be encouraged as the State has been significantly constrained by the global economic downturn and is unable to adequately resource public sector

operations including the public health services. The input of the private sector is therefore needed to ensure the availability of cutting edge technology and modalities and the state should, through some arrangement, ensure that the lower socio-economic class will be able to afford access.

## 3. SWOT ANALYSIS

| STRENGTHS | WEAKNESSES | OPPORTUNITIES | THREATS |
|---|---|---|---|
| **SERVICE DELIVERY** | | | |
| 1. A strong tradition of public health with well organised public health programs and campaigns sustained over several decades. Many technical innovations have been adopted to Jamaica and applied with great success<br><br>2. A comprehensive health system with ready access to an islandwide network of health centres and hospital including a well developed system of primary health | 1. A chronic shortage of nurses and other health professionals<br><br>2. Weak management systems and practices<br><br>3. Under-funding of the health services<br><br>4. Inadequate use of information technology<br><br>5. Inadequate physical conditions in many health facilities including poor maintenance Non-functional equipment and inadequate supplies<br><br>6. Concerns about | 1. Favourable policy and legislative framework<br><br>2. Established primary health care infrastructure<br><br>3. Existence of regional health policy planning and administration framework fosters<br><br>4. Evidence based approach to planning, management and service delivery, facilitated by<br><br>5. Implementation and use of Health Information Systems<br><br>6. Research orientation<br><br>7. Implementation of Change Management strategies<br><br>8. Strengthening policy-making, planning, monitoring and governance functions of the Head Office<br><br>9. Alternative financing | 1. Slow behaviour change in relation to sexual practices<br><br>2. Linked to child health, is the issue of the high rate of teenage pregnancy<br><br>3. HIV/AIDS problem leads to some infectious diseases e.g. tuberculosis that could retard the progress made in the reduction of infectious diseases<br><br>4. There are still Cultural practices that sometimes militate against safe sexual practices<br><br>5. The stigma and discrimination |

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|---|---|---|---|
| care and specialist care<br><br>3. The high quality of our health professionals<br><br>4. There has been impressive progress in child health in Jamaica. The immunization levels remain very high and child prone diseases are under control<br><br>5. Child Health maintains prominence among the health policy makers<br><br>6. Widespread access to potable water and sanitary facilities and a strong tradition of good hygiene among the people<br><br>7. Surveillance Programme launched by Ministry of Health and the Environment is a success<br><br>8. Significant achievements | the under-registration of deaths by the Registrar General's office<br><br>7. There are delays in the handing over of records of infant deaths to the Registrar General's office<br><br>8. There are indicators that records of deaths occurring outside of the hospitals do not reach the RGD offices<br><br>9. There are concerns expressed that recording the actual causes of deaths may be problematic<br><br>10. Children with HIV/AIDS are not properly monitored and their quality of life is often poor.<br><br>11. Concerns expressed about the recording of maternal deaths. If the mothers die some time after | strategy for the sector<br><br>10. Strengthening inter-ministerial collaboration; example with Ministries of Agriculture, Foreign Affairs & Trade, and Ministry of Education on National Food Policy<br><br>11. Evaluation of the impact of the reform process on efficiencies and effectiveness<br><br>12. Systems/processes<br><br>13. Health outcomes<br><br>14. Health Financing review | against HIV/AIDS patients are still areas of concern<br><br>6. Chronic non-communicable diseases including hypertension, diabetes and obesity<br><br>7. Injuries (intentional and unintentional) and violence<br><br>8. Mental health, including substance abuse<br><br>9. HIV, STI and TB<br><br>10. Environmental health<br><br>11. 25% of men and 34% of women are not using condoms consistently |

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| in immunization programmes<br><br>9. Maternal Health remains high on the policy agency<br><br>10. Visits for ante-natal and post-natal care remain high<br><br>11. Infectious diseases are on the decline. Malaria does not pose a problem. Jamaica is experiencing an epidemiological transition with more persons dying from chronic diseases than from communicable diseases<br><br>12. Rapid tests at clinics to screen HIV/AIDS patients<br><br>13. Costs for anti-retroviral treatment has dropped to USJ$100.00<br><br>14. Attitudes of doctors have improved and | childbirth the death is not always treated as a pregnancy-related illness<br><br>12. The deaths of the mothers who die at home because of pregnancy-related illnesses may not be recorded, as such<br><br>13. The expanded immunization programme came to an end in 2001<br><br>14. The sustainability of direct intervention is under threat<br><br>15. The discrimination practised by health workers also remains an area of grave concern<br><br>16. Men still have difficulty with the condom<br><br>17. Some persons are still not able to adequately complete their own risk assessment even when it is | | |

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| there are less complaints from patients<br><br>15. The Ministry of Health and the Environment has managed to keep the HIV/AIDS issue on the agenda<br><br>16. Condom use has improved through the years<br><br>17. There is evidence that the provision of Anti-Retroviral drugs to pregnant women who are HIV positive will reduce the transmission to their children. In the context of 900 tested positive women delivering 200 HIV positive babies the child transmission prevention pilot was implemented to reduce this possibility<br><br>18. Improved | obvious that they are at risk<br><br>18. There may be an under-recording of deaths due to HIV/AIDS<br><br>19. Females represent approximately 40 per cent of all reported cases of AIDS. The male-female infection ratio in the 10-19 age group is alarmingly high at 1 male to 2.84 females (MOH, Annual Report 2001, p. 68)<br><br>20. The contribution of injuries to the morbidity and mortality rates is high (over 30%)<br><br>21. Fee waiver may over burden the public health system<br><br>22. Inadequate focused adolescent reproductive health care (not adolescent friendly) | | |

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| social conditions including standard of living, literacy, educational level and nutrition have also contributed to improved health status<br><br>19.Fee waiver (increase access) | | | |
| **23. HEALTH CARE DELIVERY SYSTEM** | | | |
| 1. The focus on PHC<br>2. Wide geographical coverage<br>3. Fee waiver for those unable to pay<br>4. PATH benefits to the poor<br>5. Benefits of the Pharmaceutical programme<br>6. Recognition of epidemiological transition and the financial burden associated with health care for chronic conditions<br>7. Existence of a Healthy Lifestyle Policy | 1. Continuing emphasis on maternal and child health despite demographic and epidemiological changes<br>2. Elderly and men at disadvantage<br>3. No attention to gender issues in planning and implementation of health sector reform<br>4. Gap between policy formulation and implementation<br>5. Ill treatment of clients – women mainly<br>6. Inadequacies of Pharmaceutical Programmes – insufficient drugs, no | 1. Decentralization and the possibilities of improved access to local knowledge and problems<br>2. PATH spin offs on education which has the biggest impact on poverty and therefore health<br>3. Better targeting (means testing) in Pharmaceutical Programmes could bring greater benefits to those in need | 1. Continuing under financing and increase in the burden on public sector clients<br>2. Increase in complications of chronic diseases, disproportionately affecting women |

| | | | |
|---|---|---|---|
| | means testing<br>7. Inefficient and costly rural transportation<br>8. Rural women disadvantaged | | |
| **THE LEGISLATIVE ENVIRONMENT** | | | |
| 1. The gravity of many of the problems affecting health is being recognized and laws are being introduced or modified to meet the problems:<br>2. OSHA, National Workplace, Offences<br>3. Against the Person, Incest Amendment | 1. Too many are in draft too long<br>2. Laws that are outdated and not gender sensitive<br>3. Insufficient attention to changing behaviour and addressing problem of stigma and victimization<br>4. Insensitivity of judiciary | 1. Tardiness in enacting laws gives opportunity for injection of stronger gender focus. Gender lobby.<br>2. Research – gender dimensions of Occupational Hazards (OH).<br>3. Inter sex variations in OH and influence of biology and gender<br>4. Occupational hazards and the reproductive health risks to men<br>5. OH risks of sex workers | 1. The Employers' lobby in respect of the OHS Act and Workplace Policy<br>2. Intolerance, discriminatory attitudes |
| | | | |
| **HEALTH STATUS** | | | |
| 4. Increase in life expectancy<br>5. Decreased child morbidity<br>6. Decrease in population < 15 years<br>7. Changed emphasis from family planning to reproductive health<br>8. Decline in teenage pregnancy<br>9. Decline in sera- | 13. Losing gains in life expectancy<br>14. Female advantage in life expectancy and schooling<br>15. Male advantage in income<br>16. Women spend more time in illness<br>17. Women have more co-morbidity<br>18. Too little focus on reproductive health needs of men<br>19. Organization of health services | 25. Increasing working age population thus decreasing dependency ratio<br>26. Increasing size of labour force offers opportunity for increased earnings thereby allowing better financial access to health care<br>27.<br>28. | 29. Future demand for pensions, social security<br>30. Future demand for care of elderly women<br>31.<br>32. |

| | | | |
|---|---|---|---|
| prevalence in STI and antenatal population<br>10. Decline in cervical cancer<br>11. Policy on disabilities developed<br>12. | discourages use by men<br>20. HIV/AIDS risk to young women growing<br>21. Violence not integrated into reproductive health system<br>22. Teenage pregnancy still to high<br>23. Inadequate screening for cancers<br>24. Health needs of the disabled ignored | | |
| **HEALTHY BEHAVIOR** | | | |
| 33. Emphasis on four life style behaviours encourages the young to improve behaviour – smoking, alcohol consumption, drugs - that affect health in later life<br>34. Lifestyle could encourage appreciation of a life course approach to health among young<br>35. Better behaviour could improve health, but most effect on the non poor<br>36. Injury surveillance (IS) is an | 38. Lifestyle locates the problem within the individual<br>39. It does not promote equity<br>40. It does not meet the growing problem of chronic diseases among the poor<br>41. There has been no test of the representativen ess of IS data | 42. Lifestyle approach underscores the absence of opportunities for physical exercise in inner city neighbourhoods<br>43. IS can provide data for effective violence prevention programme | 44. Lifestyle emphasis can be a distraction, deemphasizing the role of socio economic conditions and poverty as determinants of health<br>45. Increasing disablement resulting from injuries<br>46. Increasing cost of treating injuries |

| | | | |
|---|---|---|---|
| important first step in prevention<br>37. IS provides comprehensive data on injuries seen at A&E | | | |

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**SECTION 2**

# THE ROAD TO 2030

*The Goal Standard*

As Jamaica posits the goal of developed country status, the question as to what exactly is a developed country arises. The goal standard towards which the country must strive has to be defined, supported by a sound philosophical framework and programmatic strategies. This should be considered in the context of what it means for our health sector.

In this regard, select health indicators provided by the State of World Population 2007, may be used as benchmarks. The specific indicators must be decided on. Table F shows a list of possible indicators and current values.

**Table F: Select population Health Indicators**

| Indicator | Value |
|---|---|
| Infant mortality Rate (IMR) | 7 |
| Life Expectancy (LE) M/F | 72.5/79.8 |
| Births/1000 women (15-19 years) | 25 |
| Contraceptive prevalence (any) | 69 |

Source: State of World Population 2007, UNFPA

Countries falling within this category include the US, Canada, Sweden, Norway and the UK. Table G looks at some of the 'more developed countries' compared with Jamaica with respect to some of the key health and economic indicators that are key to achieving whatever goals are set.

**Table G: Key Health Indicators by Country**

| Country | % expenditure of GDP on health | GNI per capita PPPJ$ 2005 | Life Expectancy M/F | Infant Mortality rate/ 1000 live births | Maternal Mortality Ratio |
|---|---|---|---|---|---|
| Canada | 6.9 | 32, 220 | 78.1/83.0 | 5 | 6 |
| United States | 6.8 | 41, 950 | 75.1/80.5 | 7 | 17 |
| United Kingdom | 6.9 | 32, 690 | 76.6/81.2 | 5 | 13 |
| Norway | 8.6 | 40, 420 | 77.7/82.5 | 3 | 6 |
| Sweden | 8.0 | 31, 420 | 78.6/82.9 | 3 | 2 |
| **Jamaica** | **2.7** | **4, 110** | **69.3/72.7** | **14** | **87** |

Source: State of World Population 2007, UNFPA

Government's expenditure on health and overall productivity has been demonstrated to have a direct relationship to health status and as such must be taken into account in the planning process. Table G shows the gap between the percentage expenditure of GDP on Health in Jamaica and the other more developed countries. Additionally, the gap

between GNI per capita in Jamaica and the other countries points to the revolutionary changes that are needed to put Jamaica in the same category.

***The way forward***

In light of the importance of health to well-being, the Health Sector Plan has sought to take cognizance of the following responsibilities/principles underlying the Government's responsibility for health:

- provision in respect of goods that are public, and services with large externalities
- services that lead to poverty reduction and the widening of people's choices and
- interventions to solve problems emanating from uncertainties surrounding health and from insurance market failures.

The recommended approaches for the government to employ in meeting its responsibilities for the health needs of its population are to:

1. foster and encourage improvements in the determinants of health ( related to the economic, social and environmental conditions)
2. improve the cost effectiveness of Government spending on health – through provision of appropriate packages of public health and clinical health services
3. promote diversity and competition in the health care provision and health insurance markets.

The issues to be addressed are developed under the categories below.

1. Social determinants of Health
2. Health Care Resource Provision
3. Service Delivery (Quality, Access, Availability)

## SOCIAL DETERMINANTS OF HEALTH

### The Jamaican Experience

The maintenance of health is not the sole purview of Ministries of health. There is mounting evidence supporting the view that many of the determinants of health are in fact in the social and economic realm. This recognition has far-reaching implications

for policy formulation and development at all levels of national life. Risky behaviour, for example, is often rooted in social vulnerability and cultural practices including gender stereotypes and inequity. Many of the risk factors affecting the health of Jamaicans are either not perceived by the population as such, or they are only superficially understood. These include obesity/overweight, cigarette and/or marijuana smoking, heavy alcohol intake, a fatty, high salt diet with a lot of refined sugars, sedentary lifestyle, failure to adequately treat hypertension and diabetes mellitus, multiple sex partners and poor health seeking behaviour.

The determinants which have been shown to impact health include:

- Socio-economic status / Income/ Employment
- Education
- Environment – work, housing, physical environment (vector control etc
- Nutrition and food security
- Lifestyle & Risk factor: Control over ones life/stress/ psychological factors/crime and violence
- Cultural factors
- General living conditions/poverty/ discrimination, social exclusion and opportunities for social support and networking
- Transportation
- Genetics

With respect to the MDGs, it is argued that the policies required for top and high priority countries to break out of their poverty traps involve investing in health and education[25]. These investments contribute to a cyclical process involving economic growth and human development. Investments in education, health, nutrition and water and sanitation result in complementary impacts whereby, investments in any one contributes to better outcomes in the others. More than just a source of knowledge, education promotes better processing of health information and increases the use of

[25] The Human Development Report, 2003

health services; safe water and adequate sanitation also determine health outcomes; reducing infectious diseases leads to improved nutritional status of children and increases their learning abilities.

Addressing determinants outside the sector requires:

- deepening and widening inter sectoral collaboration with relevant agencies /institutions and sectors to impact policies and programmes related to the determinants of health;
- advocacy for the review, establishment and enforcement of appropriate initiatives, policies and regulations to support the provision of a healthy environment, appropriate housing solutions and decent living conditions;
- strengthening the capacities of parents for supporting the development of their children;
- advocacy for//Establishment of counselling and public education services to reduce the consequences of poor life choices and inadequate income and other support and
- creating the institutional mechanisms in which poor users of health and other services can demand accountability and transparency from service providers.

## HEALTH CARE RESOURCE PROVISION

This section addresses the critical resource needs of the sector to facilitate Jamaica reaching developed country status by the year 2030. The key resources identified are:

- Human Resources
- Physical Resources
- Financial Resources

### *HUMAN RESOURCES*

The MOHE has largely driven the production and distribution of the sector's human resources. However, over the years the supply in respect of numbers and competencies has not kept apace with the demands.

Many reasons exist for the inadequate numbers of professionals. These include emigration to more attractive remunerations overseas, inadequate remuneration and poor working conditions. Training opportunities in some instances are available overseas only, as in the case of therapeutic radiographers, and the incentives in terms of remunerations and technology are absent. To relieve the impact of staff shortages, contractual arrangements have been made with the governments of a number of countries to provide personnel, including physicians, nurses and pharmacists. These countries include Cuba, Nigeria and Ghana. This is a less sustainable approach.

Staffing in the Regional Health Authorities is significantly below the established cadre[26] in most categories of health care professionals, except for physicians. Allocation of staff also poses a challenge. The Report on the Caribbean Commission on Health, 2006, suggests that there is oversupply of staff in some RHA while other RHAs experience shortage of similar skills. Inadequate staffing of the health centres (for diagnostic, treatment and pharmaceutical services) affects the use of the Health Centres as the primary care facility, resulting in increased workload in hospitals. Rural areas are also understaffed, when compared to urban areas. Vacancies are approximately 871 persons (19%) of a total cadre for critical health staff categories of 4 609, with the nursing categories totalling 677 vacancies or 77 per cent of the total vacancies (Appendix 4).

The cadre allows for employment of 2 563 professional nurses, however only 1 886 (73%) are employed. The low nurse to patient ratio has a negative impact on the delivery of health care. Within the context of health sector reform, the Ministry of Education has begun to play a major role in the development and training of human resources for health. The University of Technology (UTECH), has commenced training of entry level Registered Nurses.

[26] An assessment is being conducted that will inform a more realistic cadre

There are 2 924 physicians registered with the Medical Council of Jamaica[27]. The numbers employed do not include locums, who in some instances are fully registered and qualified medical doctors in other jurisdictions but are not registered with the Medical Council of Jamaica. A total of 715 doctors are employed to the Regional Health Authorities, 109 above the established cadre. Eighteen per cent of doctors employed are working in primary care settings, as against the allocation of 26 per cent of posts in the cadre. UWI employs approximately 400 doctors and 500 nurses.

The additional cost to fill these vacancies along with additional critical staff is approximately J$1 156B (see Appendix 4). The foregoing does not take into account the need to influence staff allocation by informed assessment of the appropriate ratios and skills mix required to meet the current and emerging needs.

The human resource needs assessment currently being undertaken by the MOHE will need to be informed by the strategic reorientation towards a primary health approach. This approach requires attention to key areas of expertise, inter alia, health planners, health promotion specialists, expertise to monitor and evaluate health programmes, health informatics, researchers and epidemiologists, appropriately qualified public health specialists, including public health doctors, nurse practitioners and public health nurses. Increased numbers of pharmacists, case managers, allied health professionals such as social workers, competent and adequately remunerated managers will also be required. Public health specialization /primary care employment should be made as attractive as hospital employment, as a means of attracting qualified and competent staff.

HR Priority Areas for the Future include:

1. enhancing skills mix and improving the deployment of HR;
2. passing of legislations required to give the Nurse Practitioner legitimacy to write prescriptions for specific drugs;

[27] 2008 January, Medical Council of Jamaica..

3. implementation of Performance Management – results based environment and mechanisms;
4. design and execution of training plan to meet HR needs in a sustainable manner (The training plan should be informed by a cost effectiveness study that gives consideration to application of subsidy for development of health professionals that are in short supply, rather than for areas where there are adequate or oversupplied. This calls for a dovetailing of HR development plan and the strategic development plan for health); and
5. development of a recruitment and retention plan (including managed migration, remuneration and sustainable training of staff).

***PHYSICAL RESOURCES***

*Buildings*

Most of the buildings from which the public health care system operates are over 30 years old, and their maintenance has been compromised due to inadequate funding. Major upgrading will be necessary, and in some cases expansion, to accommodate increased patient flow with increased utilization arising from the abolition of user fees. This has been experienced at Bustamante Hospital for Children where a 30 – 40 per cent increase in patient flow was recorded.

The cost implications are crudely estimated at J$2.0B for renovation and improvement of the existing health facilities. With the exclusion of the post-Hurricane Dean repairs, the estimates are approximately J$300M. Appendix 2 gives a breakdown of the estimated costs for Infrastructure. Expenditure on health facilities during the 2007/2008 fiscal year totalled J$106.91M. The National Health Fund's (NHF) Institutional Benefits programme has been the major source of financing.

*Equipment*

Within the public sector, much of the equipment has already served its useful life and a number are in need of replacement. In addition, a number of hospitals and health centres are functioning without equipment that is mandatory in such facilities. The

resulting extended turn-around times for diagnostics reports, foregoing of service, as well as high costs to patients who have to resort to accessing the services privately, all have negative impact on patients' health.

The high cost of equipment, and the even higher cost of maintaining them requires a system for ensuring the cost effective use of technology. There is no evidence that the purchase of equipment is informed by technology assessment at the national level, a function that Health Economists within the MOHE could help to support. Assessments should involve cost effectiveness studies, and provide information on quantities, ideal location and a referral system for optimal use.

In 2006, the sum of J$720.9M or approximately 64 per cent of approved grants was allocated to replace obsolete equipment with new medical equipment, including equipment for diagnosis of Asthma, physiotherapy equipment, 40 new ambulances, and Public Health Inspectors' Equipment.

The upgrading of radiology technology initiative in the public health sector is the largest project ever undertaken in radiology in Jamaica. The project, funded by the National Health Fund, is geared at providing public hospitals with a total of 82 new pieces of radiology equipment over a three-year period. The installation of the 40-slice CT scanner at Kingston Public Hospital will enable the radiology department to perform a wide range of applications in the diagnosis of numerous conditions. Maintenance of equipment is also a weakness, and will require attention to developing the appropriate sustainability mechanisms, including the appropriate skills and resource for maintenance.

The proliferation of radiation technology, which is utilized for diagnostic and therapeutic purposes, will require expansion of government's infrastructure for ensuring radiation protection. Equipment used for treating diseases like cancers, and for diagnoses (CT scanners, for example) can cause injuries (skin damage, cancers, death, foetal impairment), if standards and protocols are not maintained. Currently, government has commenced the development of Radiation Protection Infrastructure,

which comprises the establishment of a Radiation Protection Authority and Radiation Protection legislation. These will enable and facilitate monitoring of private and public sector facilities to ensure radiation safety for client, workers and the general public.

Expenditure on equipment during the fiscal year 2007/2008 totalled J$114M. Projected expenditure for the next five fiscal years is shown in Table H.

**Table H:**

**Projected Expenditure for the next five fiscal years**

| **Projections** | J$ | | | | |
|---|---|---|---|---|---|
| | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** |
| Infrastructure | 401.18 | 401.18 | 401.18 | 401.18 | 401.18 |
| Equipment | 129.75 | 129.75 | 129.75 | 129.75 | 129.75 |
| **Total Capital Projections** | **530.94** | **530.94** | **530.94** | **530.94** | **530.94** |

The estimated cost to purchase the required equipment is approximately J$648M (See Appendix 2 for an assessment of expenditure of infrastructure and Equipment of health facilities).

*Transportation*

The availability of specific modes of transport within the health sector and specifically the public sector has improved over the years with the acquisition of several new ambulances by the State and their deployment at all public hospitals across the island. There is still the call however for the availability of air ambulances as well as wide scale implementation of Emergency Medical Services (EMS), given the prevalence of motor vehicle accidents on the nation's streets. It is felt that the provision of these additional services will ultimately result in the saving of more lives although they may be cost prohibitive.

*National Health Information System (NHIS)*

A National Health Information System comprises the multiple sub-systems and data sources that together contribute to generating health information, including vital registration, censuses and surveys, disease surveillance and response, service statistics and health management information, financial data, and resource tracking. Within the health sector, Information, Communication Technology (ICT) can be used to facilitate information requirements of Managers and Planners, as well as health and medical care.

Within the Jamaican public health sector, the absence of a successful centrally driven initiative to implement a system that meets the information needs of stakeholders has resulted in a plethora of separate and often overlapping systems. The NHIS in the public sector comprises the central National Health Information System consisting of five (5) major standalone databases which generate the requisite reports using data from 23 hospitals and 322 health centres as well as several health systems/databases which are not directly linked to the central HIS. These information databases include the HIV/AIDS surveillance (HATS), Injury surveillance which has spatial representation (GIS capability) and Communicable Disease Surveillance. The Health Information Systems within the head office itself are all isolated and do not exchange data even when they exist in the same department and collect almost identical information.

The Regional Health Authorities have a reasonably integrated system within their regional offices, this does not however, extend into health centres and hospitals. There is no interface between the MOHE's system and that of the RHA. The current Patient Administration System (PAS), used in 13 hospitals and two clinics islandwide, emphasizes the capture of summary patient information at an institutional level. PAS has no national standard for the identification of unique records, and is not used beyond the extracts sent in the Hospital Monthly Summary Reports. A lack of transferability and inadequate sharing of patient data characterize the HIS. The heavy reliance on manual entry of data at several points in the data capture and transmission process, coupled with the inability to cross check information across departments, contribute to the data inaccuracies.

Recent discussions have focused on the need for modern information technology (hardware, software and connectivity), for capturing and transferring data on a real time basis. There is interest from the private sector for public facilitation of telemedicine, which require the network and facilities for referral within and outside of the public health sector, remote imaging and diagnostic services, and remote management of patients. The legislative and policy environment is an essential part of the infrastructure required to support the private sector's vision of a modern state-of-the-art private health sector that provides telemedicine, health tourism and outsourcing health services.

The Government is committed to increasingly embrace ICT for health where it is demonstrated that its application will improve the efficiency and cost effectiveness of health care to its population. The laboratory health information system is evidence of that commitment. The realities are, however, that while ICT has the potential to transform a health system, its capabilities can be undermined by a failure to establish the platform for its effectiveness and maintenance. This platform includes an information policy; regulatory and legislative framework to support client records/information sharing and ownership; a strategy for expanding, upgrading and maintaining the system; as well as appropriate attention to the softer personal, cultural and institutional factors.

The first step to developing a national HIS is the preparatory phase, which will facilitate development of the policy, legislative and regulatory framework. The policy and legislative framework is important in the discussions on confidentiality, ownership of data/patient and telemedicine, and will be informed by analysis of issues surrounding data accuracy, data processing and information needs for the decision-making processes. It will take into account recommendations of HIS consultants who noted that the data being captured were extremely under-utilized in the decision making process and that the quality of the health information system was compromised due to failure to record vital information on patient care.

The Ministry is about to spearhead the development of a comprehensive strategy for the development of a national health information system, supported by appropriative polices and legislations that speak to issues of electronic records, patient information confidentiality and ownership, as well as stakeholders' responsibility and obligation. The strategy requires a comprehensive assessment of the needs, cost effectiveness and scope of the health information system needed to provide information and evidence for health system planning and management, as well as for patient care. The strategy and plan will address implementation and maintenance of the system over a 20-year period.

The government strategy will facilitate the provision of information and evidence to its stakeholders to inform the planning, implementation and evaluation of the health care system and services, as well as for fulfilling its accountability role.

The proposed NHIS will:

- facilitate the capture of patient demographics, the generation and storage of health records, and the production of reports and statistics for use by institutions, regional health authorities and the MOH and its subsidiaries and agencies;
- assist in determining where resources are best utilized and will assist in scheduling these resources;
- electronically store and manage large volumes of information;
- streamline mechanism for analysis of clinical processes that may optimize patient care;
- reduce the need for some surveys which are currently undertaken in the absence of reliable data from the health information system; and
- better target the poor for appropriate services and benefits.

Immediate plans in this respect are as stated below.

1. The Formulation of a Health Information Policy

2. Development of relevant and appropriate legislation in a timely manner to support the implementation of the Health information policy and strategy
3. Health Information Strategy and Action Plan, to guide the development of a National Health information system over the next 20 years

   Note: The Preparatory activities to inform the strategy and policy phase have commenced.

*Supplies*

The availability of supplies to meet the needs of the sector is critical in ensuring a sustained and structured approach to development. Supplies refer to:

- pharmaceuticals;
- vaccines; and
- other administrative or accessory items.

The Ministry is consistently challenged to finance the procurement and provision of adequate supplies of drugs, resulting in hospitals and health centres oftentimes out of stock of vital drugs and supplies. This causes delays in providing medical care resulting in unnecessarily lengthy hospital stays and even cancellation of some surgeries.

The budget for drugs and medical sundries for the current fiscal year is J$981MM. Analysis received from Health Corporation Limited of the projected cost of drugs and supplies for the coming fiscal year highlights the need for approximately J$1.7B for drugs and medical supplies. The calculation of this cost is detailed in Appendix 3.

***FINANCIAL RESOURCES***

Implicit in the rights of citizens to health is the availability and accessibility of equitable, appropriate and affordable health care. The government has a role to play in protecting persons from the catastrophic risk associated with illnesses. It is for this reason that some governments feel the obligation to put in place a system whereby fees do not represent a barrier to health care access.

The increasing cognizance of the right of access to adequate health care services is occurring against the background of the emergence of new forms of health care and treatment, driven by changes in demand. The impact is therefore twofold: rising health care costs; and decreasing levels of affordability by the poor and vulnerable. The implication for health care costs and associated expenditure highlights the imperative for provision of a basic health benefits package for the poor that is financed by the government. This provision is also motivated by the principle of redistributive transfer from wealthy to poor, healthy to sick, working to dependent population, as well as protection of individuals from catastrophic financial risk occasioned by illness.

The development plan for the health sector must therefore seek to put in place mechanisms to enhance the government's capability to provide equitable access to health care services to the entire population, regardless of risk or income and contain cost, as well as allocate resources in an efficient manner for optimal health outcomes.

The three main areas of focus for the government are:

1. Enhancing resource mobilization for the provision of health services
2. Financing of health care –
    - who pays for health care;
    - the mechanism by which payment is made (out of pocket, taxes, private insurance) adequacy and efficiency of the mechanisms;
    - allocation – quantity and mix of services, and for whom; and
    - distribution – Who benefits (includes consideration of equity/redistribution).

3. The health service financing management -
    - who pools the fund and organize for purchasing of health care services
    - method of remunerating service providers

The context within which the GOJ operates is one of tight fiscal and budgetary space, a growing private sector and the need to limit out of pocket health expenditure. Given the limited resources available to the government, the options are:

1. increased taxation (progressive) for full public financing of essential public health and clinical services packages, or;

2. full public financing of essential public health package, coupled with full public financing of a clinical package for the poor only, with appropriate levels of fees applied to the wealthy for essential clinical services package. This latter option implies:
    - greater government responsibility for regulating/oversight of the private insurance industry;
    - greater costs and effort associated with targeting – to ensure the benefits are accessed by those most in need; and
    - greater role for the private sector to respond to the provision of services to the high end of the market.

The Public Health sector is financed primarily from Government of Jamaica (GOJ) budgetary allocations, inputs from Non-Government Organizations (NGOs), and International Development Partners (IDPs) (See Table I).

**Table I:**

**Source of Funding for the Public Health Sector**

| **Sponsor** | **Source** | **Approximate (J$)** |
|---|---|---|
| Government of Jamaica | Recurrent<br>Capital | 19B<br>900M |
| | National Health Fund<br>Individual Benefits (currently)–<br>Institutional Benefits – | <br>1B per annum<br>4B ( 3 years) |

| | | |
|---|---|---|
| | NI Gold –<br>CHASE - | 250MM per annum<br>150MM per annum |
| | Foregone Duty Waivers (for private heath facilities,)<br><br>Waivers of Statutory Deductions for private health facilities | not known<br><br>not known |
| Private | Private equity<br><br>Health Insurance payments<br><br>Out of Pocket Contributions | <br><br>– over 6B in 2006 |
| Multilateral (loans and grants) | PAHO (Mostly training/TAs)<br>World Bank (HIV/AIDS<br>Global Fund (HIV/AIDS)<br>IDB | |

Source: MOHE

Considerations in respect of health financing options:

- "Health financing mechanisms are options of how to offer financial risk protection to people against the cost of healthcare. These include tax-based financing, social health insurance, private health insurance and medical savings account[28]." The pragmatic question should be, "What is Jamaica's economic reality and which of these options or variants can be supported by the economy?"

- Objective assessment of health financing programmes such as JADEP, NHF is necessary. A performance review could indicate that a development of a sustainable financing scheme may necessitate departure wholly or in part from these existing schemes.

- The role of the private sector in financing health care cannot be ignored, even with a definition of a basic package of health care.

[28] See Glossary

- Decision on a financing methodology requires a clear policy guideline on the strategic objective of the health system, the strategies, targets and priority programmes.

- There has been no substantial scientific review of the present health financing system. Consequently the Plan is unable to present the hard evidence for a complete shift from the present system of financing. All financing systems, however, have their strengths and weaknesses and therefore the evidence could inform the proposed financing mechanism. The point must be underscored that "Abolition of user Fee" is only one component of a more comprehensive and sustainable national health financing strategy that the Government must develop. The discipline of Health Economics must be applied to the selection of feasible options.

- An evidence-based approach to planning also implies the evaluation of the impact of any financing mechanism. Current international indicators of health status may reflect only marginal changes, masking the full impact on the quality of health and life of the population. The development of indicators which measure the quality of health is recommended.

**Priority areas for future intervention**

1. Greater involvement of the Health Economists in designing a health financing strategy

2. Design of a Universal basic health benefits package – driven by public health and primary health care consideration

3. National health Insurance provision

4. Evaluation of current health financing – include all current income streams

5. Design of a plan for sustainable health financing

6. Evidence-based budgeting and accountability for financial resources

7. Cost effectiveness reviews of health financing options

8. Health technology assessments

9. Integration of social protection programmes and health care/financing

10. Alignment of the budgeting process with the Strategic and Operational Planning processes

***HEALTH SERVICE DELIVERY***

The three-tier approach (primary, secondary and tertiary) in the delivery of health care has for a long time been the centre of Jamaica's public health sector, the very nature of which reflects and responds to prevailing social, economic and epidemiological realities. It must, however be understood that while Jamaica embraces the notion of 'Health for All', economic realities limit the degree to which this can be meaningfully achieved without compromising quality. Service delivery mechanisms must therefore continue to be underpinned by the principles of quality, accessibility, availability, affordability and equity. Policy and programmatic interventions must continue to be formulated on the basis of scientific evidence and epidemiological justification. Coordination and partnership with regional states and private investors must be viewed as a means of complementing the public health sector.

The approach to be taken in the delivery of health care by the public sector is presented below.

**1. Planning Service Delivery:p**

This will involve the following:

- identifying population based conditions to be treated as priority – based on disease burden;
- identifying strategies for prioritization and intervention

-Life Cycle, concerns; and

- planning and monitoring health programme (clinical and non-clinical) standards and protocols.

**2. Delivery of Non-clinical service for Public Health (Population based services):**

- Surveillance and research for evidence based planning for a Public /Population approach

- Address determinants of health (health and non-health sector)
  - Health sector - Through Health promotion & Wellness strategies
  - Non-health sector – Inter-sectoral collaboration and advocacy

Environmental Health services will span sectors.

<u>Priorities</u>

- Disease Surveillance (Re-emerging, existing and potential threats)
- Environmental health
  - Water and sanitation
  - Vector control
  - Environmental toxins
  - Communicable diseases
  - Healthy workplace environment
- Wellness and Health promotion – focusing on social, cultural and personal lifestyle issues
  - Lifestyle – nutrition, obesity, exercise, sexual risks, substance abuse
  - Violence (includes interpersonal /relationship violence)

- Road accidents
- Provision of public amenities, e.g. parks
- Regulations regarding housing development – minimum standards, example, green space, parks, safety features
- Address inappropriate music content for public consumption that promote risky sexual behaviours and violence
- Supportive healthy food policies
- Healthy relationships

**3. Delivery of Clinical services:**

Clinical services are classified into:

- Preventative/Primary care service - Immunization, Screening, Maternal & Child Health
- Secondary care – Secondary Prevention and Restoration- limit disability, reduce morbidity and mortality
- Tertiary care - Rehabilitation and palliative care

Primary Care services

The goal of primary care is to prevent the incidence of disease conditions (new cases). Primary care services are designed to achieve risk reduction, specific protection or early detection and treatment. The clinical based prevention programs are delivered through the primary care system

Primary Care Strategies include the following:

- community involvement;
- environment monitoring and intervention;
- screening programmes;
- early clinical intervention;
- building the capacity of support services e.g. Home health care; and

- utilizing health team approach & auxiliaries e.g. Community Health Aides (CHAs), Nurse Practitioners.

Secondary Care services

Aimed at restoring health and preventing morbidity and mortality. The issues in secondary care include:

- high incidence of accidents & trauma;
- inappropriate use of emergency/A&E depts.;
- under-developed emergency medical services; and
- absence of effective health information system.

Secondary Care strategies include**:**

- development of standards of care;
- modern governance system in healthcare; and
- encouragement of private investment to improve quality and quantity of service delivered to the population

Tertiary Care Services

Tertiary care refers to specialist and rehabilitation services which are currently offered in institutions such as the National Chest Hospital, Sir John Golding (Mona Rehab), Bellevue Hospital, Nursing Homes.

**The Goal** of tertiary care is to avert chronicity through rehabilitation and to enable functionality.

**Tertiary Care** Strategies:

- develop multidisciplinary plans for new services;
- promulgate appropriate legislation; and
- develop standards of care for these facilities; Develop manpower needs for adequate staffing.

# 4. STRATEGIC VISION AND PLANNING FRAMEWORK FOR THE HEALTH SECTOR

The long-term process of planning for the Health Sector is guided by a Vision that describes a desirable future for the sector and its stakeholders and which may be achieved through their own efforts within a realistic time frame. The Sector Plan is responsive to the issues raised in the foregoing discussion on the "Road to 2030". It contains an overall Vision for the Health Sector, which reflects the contributions of the stakeholders represented on the Health Task Force and at stakeholder consultations held during the Vision 2030 Jamaica planning process.

## Vision Statement

The Vision Statement for the Health Sector for Vision 2030 Jamaica is:

***"Healthy lifestyles in a healthy environment creating/producing healthy people"***

## Strategic Approach

In responding to the issues raised, the Health Task Force recognized that advancement in the health of the nation beyond the point that has been achieved can only be realized if our population begins to take greater responsibility for its own health. The Health Promotion Approach will therefore be taken to support the development of healthy environments and healthy lifestyle choices in our population. Simultaneously, the health system will be refocused to provide high quality and comprehensive care at the primary level both as a method of promoting basic health care and of preventing elementary health problems from growing into chronic and serious diseases. The care pathway will be properly defined to ensure that users of the health system will be able to identify the appropriate health facilities to visit when seeking institutional support for health issues. This will prevent overcrowding of hospital emergency rooms with primary health care concerns.

The process of improvement of the secondary and tertiary care facilities will continue. With the expected improvement in primary care, and personal responsibility for maintaining one's health, the secondary and tertiary care institutions will be relieved of much of the demand for these facilities and this will make it possible for them to be adequately resourced to provide high quality service to their clients.

At all levels of the system, a multidisciplinary team of workers and corresponding facilities will be provided to ensure adequate responses to demands that may be made upon these facilities. Additionally, flexible operating hours will be introduced into primary health care operations to ensure that whenever emergency care is required, the institutions will be able to provide it, thereby preventing overcrowding of hospital emergency rooms at nights.

It is important that the health system be financed at a level to be able to sustain high quality facilities and services. To this end, new financing mechanisms will be explored

including the design and implementation of a national health insurance scheme, the expansion of the scope of the National Health Fund, public private partnerships in delivery and financing and modalities such as health tourism.

Finally, development of the system will be information driven and to this end, the Essential Health Research Committee (ENHRC) will be established. This will ensure the evidence-based decision making and the development of policies, plans, programmes and standards within the health sector.

## Goals and Outcomes

The five (5) main goals and associated outcomes of the Health Sector Plan are presented in Table J below.

**Table J: Goals and Outcomes**

| Goals | Outcomes |
|---|---|
| **1.0 Social, cultural, physical and economic conditions that support the health and wellbeing of the Jamaican society** | 1.1 An effective system for disease surveillance, mitigation, risk reduction and responsiveness to disease threats |
| | 1.2 A culture of responsibility for wellness is encouraged in the Jamaican society |
| | 1.3 The Primary Health Care Approach is fully strengthened and emphasized |
| | 1.4 The physical environment in Jamaica is healthy and sustains the health of the population |
| | 1.5 The national food policy is supported |
| **2.0 High quality facilities for health services delivery** | 2.1The quality of the health infrastructure is high and works efficiently |
| | 2.2 Decision making is supported by a national health information system |
| **3.0 A cadre of world class human resources for the health services** | 3.1 Staffing needs are adequately addressed |
| | 3.2 The level and quality of outputs of staff are high |

| Goals | Outcomes |
|---|---|
| **4.0 World class and accessible health service delivery** | 4.1 The health sector is effectively governed |
| **5.0 Sustainable, equitable, efficient and effective public health financing accessible by all** | 5.1The health sector is adequately financed |

## Sector Indicators and Targets

The proposed indicators and targets for the Health Sector Plan over the period 2009 - 2030 are presented in Table K below.

**Table K: Health Sector Plan – Proposed Indicators and Targets**

| Sector Indicators | Baseline | Targets | | | Comments |
|---|---|---|---|---|---|
| | 2007 or Most Current | 2012 | 2015 | 2030 | |
| 1. Child mortality rate (under 5/ 1000) | 21.4 | | | | |
| 2. Maternal mortality (/100,000) | 95 | | | | |
| 3. HIV/AIDS prevalence rate (15-49) | 0.015 | | | | |
| 4. # of New cases of HIV/AIDS | 324 | | | | |
| 4. Total fertility rate | | | | | |
| 6. % change in Net External Movement | 21.4 | | | | |

# 5. IMPLEMENTATION FRAMEWORK AND ACTION PLAN FOR THE HEALTH SECTOR

## Implementation Framework

The implementation of the Health Sector Plan is an essential component of the implementation, monitoring and evaluation framework for the Vision 2030 Jamaica – National Development Plan. The Plan is implemented at the sectoral level by ministries, departments and agencies (MDAs) of Government as well as non-state stakeholders including the private sector, NGOs and CBOs. The involvement of stakeholders is fundamental to the successful implementation of the National Development Plan and the Health Sector Plan.

## Accountability for Implementation and Coordination

The Cabinet, as the principal body with responsibility for policy and the direction of the Government, has ultimate responsibility for implementation of the National Development Plan. Each ministry and agency will be accountable for implementing the National Development Plan (NDP) through various policies, programmes and interventions that are aligned with the strategies and actions of the NDP and the sector plans. A robust results-based monitoring and evaluation system will be established to ensure that goals and outcomes of the Plan are achieved. This system will build on existing national and sectoral monitoring and evaluation frameworks and will be highly participatory.

### Components of Vision 2030 Jamaica

The Vision 2030 Jamaica - National Development Plan has three (3) components:

1. Integrated - National Development Plan:
   The integrated National Development Plan presents the overall plan for Vision 2030 Jamaica, integrating all 31 sector plans into a single comprehensive plan for long-term national development. The integrated National Development Plan presents the National Vision, the four National Goals and fifteen National Outcomes, and the National Strategies required to achieve the national goals and outcomes.
2. Medium Term Socio-Economic Policy Framework (MTF):
   The Medium Term Socio-Economic Policy Framework (MTF), is a 3-yearly plan which summarizes the national priorities and targets for the country and identifies the key actions to achieve those targets over each 3-year period from FY2009/2010 to FY2029/2030.
3. Thirty-one (31) Sector Plans:
   At the sectoral level Vision 2030 Jamaica will be implemented through the strategic frameworks and action plans for each sector as contained in the respective sector plans. Vision 2030 Jamaica includes a total of thirty-one (31) sector plans covering the main economic, social, environmental and governance sectors relevant to national development.

## Resource Allocation for Implementation

Vision 2030 Jamaica places great emphasis on ensuring that resource allocation mechanisms are successfully aligned and integrated with the implementation phase of the National Development Plan and sector plans. The requirements to ensure resource allocation for implementation will include alignment of organizational plans in the public sector, private sector and civil society with the National Development Plan, MTF and sector plans; coherence between the various agency plans with the National Budget; rationalization of the prioritization process for public sector expenditure; and increased coordination between corporate planners, project managers and financial officers across ministries and agencies.

## Action Plan

The Action Plan represents the main framework for the implementation of the Health Sector Plan for Vision 2030 Jamaica. The tracking of implementation of the Health Sector Plan will take place through the Action Plan as well as the framework of sector indicators and targets.

The Action Plan contains the following elements:

i. Sector Goals
ii. Sector Outcomes
iii. Sector Strategies
iv. Sector Actions
v. Responsible Agencies
vi. Timeframe

# ACTION PLAN

| OUTCOMES | STRATEGIES | ACTIONS | TIME FRAME | RESPONSIBILITY |
|---|---|---|---|---|
| **GOAL 1: SOCIAL, CULTURAL, PHYSICAL AND ECONOMIC CONDITIONS THAT SUPPORT THE HEALTH AND WELLBEING OF THE JAMAICAN SOCIETY** | | | | |
| 1. 1 An effective system for disease surveillance, mitigation, risk reduction and responsiveness to disease threats (National Strategy 1-2) | 1.1.1 Enhance early screening/detection programmes | Establish environmental screening programmes | 2010 - 2015 | MOHE |
| | | Promote early clinical intervention | 2010 - ongoing | MOHE |
| | | Strengthen the channels for public communication | 2010 - onwards | MOHE<br>CBOs<br>FBOs<br>Various media houses |
| | | | | |
| | 1.1.2 Prioritize national | Control and/or eliminate | 2009/10 - | MOHE |

| OUTCOMES | STRATEGIES | ACTIONS | TIME FRAME | RESPONSIBILITY |
|---|---|---|---|---|
| | epidemiology issues | communicable diseases such as Malaria | ongoing | |
| | | Strengthen the current national response to HIV/AIDS by scaling up prevention services and access to treatment for persons with HIV/AIDS | 2009/10 | MOHE<br>NGOs<br>FBOs |
| | | Increase public awareness and personal responsibility re communicable diseases | 2009 - ongoing | MOHE<br>JIS<br>Media houses |
| | | | | |
| | 1.1.3 Introduce a research agenda and programme to support informed decision making | Formulate a research agenda focussing on diseases | 2010 - 2011 | MOHE<br>Universities |
| | | Build the institutional capacity to undertake and support research | 2011 -2013 | MOHE |
| | | Identify mechanisms for sustained funding of research | 2010 onwards | MOHE<br>MFPS |
| | 1.1.4 Strengthen primary, secondary and tertiary prevention programmes | Revitalize the primary care approach | 2010 - 2011 | MOHE |
| | 1.1.5 Improve risk./disaster mitigation through prevention, preparedness and response | Collaborate with ODPEM To identify various approaches to mitigation | 2011 - 2013 | MOHE<br>ODPEM |
| | | Establish mechanisms to monitor and enforce compliance | 2011 onwards | MOHE |
| | | | | |
| 1.2 A culture of responsibility for wellness in the Jamaican population (National Strategy 1-3) | 1.2.1 Strengthen the policy framework and reorient the health system to support the healthy lifestyle approach | Introduce and implement Tobacco Control Legislation | 2009 | MOHE |
| | | Develop and implement the appropriate legislation, standards, guidelines to support healthy lifestyles | 2010-2011 | MOHE<br>Cabinet |
| | 1.2.2 Empower communities to support enhancement of the healthy lifestyle approach | Build healthy zones in communities | 2014 - 2030 | MOHE<br>NGOs<br>CBOs<br>PDCs<br>Local Government Authorities |
| | | Introduce emergency crisis outreach teams at the parish level and acute services at each regional hospital | 2011 - ongoing | MOHE<br>Umbrella employer organisations |
| | | Implement effective screening and follow-up programmes | 2011 - ongoing | MOHE |

| OUTCOMES | STRATEGIES | ACTIONS | TIME FRAME | RESPONSIBILITY |
|---|---|---|---|---|
| | | Build mechanisms to foster community participation in wellness promotion | 2010 - ongoing | MOHE<br>NGOs<br>FBOs<br>CBOs |
| | | Develop an effective, ongoing public communication/information system | 2010 - 2011 | MOHE<br>Various media houses – public and private |
| | | Develop personal skills of individuals to make informed choices | Ongoing | MOHE<br>MOE<br>FBOs<br>CBOs |
| | | Strengthen the community based approach to mental health | 2009 - onwards | MOHE<br>CBOs<br>FBOs |
| | 1.2.3 Build Strong alliances with key stakeholders to support the healthy lifestyles approach | Strengthen the workplace wellness programme | 2010 - 2011 | MOHE<br>FBOs<br>OPM<br>Employers |
| | | Support implementation of the building code and ensure the introduction of green spaces and recreational facilities | 2010 | MOHE<br>Bureau of Standards |
| | | Encourage physical activities | Ongoing | MOHE |
| | | Ensure that a healthy environment is encouraged (e.g. smoke free environment) | 2010 - onwards | MOHE<br>OPM<br>Cabinet |
| | | Support adequate nutrition at school and home | Ongoing | MOHE<br>MOE |
| | | Strengthen programmes to support mental health | Ongoing | MOHE |
| | 1.2.4 Mainstream demographic considerations such as gender differentials in health conditions and health seeking behaviour to address issues such as the reluctance of men to seek health care | Ensure that staff is trained to be gender and age sensitive | 2011 - 2015 | MOHE<br>Health Training institutions |
| | | Ensure that facilities are designed to facilitate gender and age differentials | 2012 - 2030 | MOHE<br>Private sector<br>NGOs<br>CBOs<br>FBOs |
| | | Introduce a policy that will ensure that the design and implementation of public information campaigns are gender and age sensitive | 2012 | MOHE<br>Bureau of Women's Affairs<br>UWI Gender Department |
| 1.3 The primary health care approach is fully | 1.3.1 Ensure efficient allocation of resources to support the primary health | Increase the level of financing and resources allocated to support | 2009 - onwards | MOHE<br>MFPS<br>Cabinet Office |

| OUTCOMES | STRATEGIES | ACTIONS | TIME FRAME | RESPONSIBILITY |
|---|---|---|---|---|
| strengthened and emphasized (National Strategy 1-4) | care strategy | primary health care | | OPM |
| | | Rationalize the allocation of resources between the various levels of health care | 2009 - onwards | MOHE |
| | | | | |
| | 1.3.2 Build adequate support services and mechanisms to ensure seamless transition throughout the care pathway – from primary to tertiary level care | Ensure that each level along the care pathway is adequately equipped to provide the targeted level of care | See strategy 1.3.5 | MOHE |
| | | | | |
| | 1.3.3 Strengthen the capacity of tertiary health care facilities to provide vital services that are not delivered at the primary level | Adequately equip and staff tertiary level institutions to deliver high quality tertiary level care in all the required disciplines | 2010 - 2020 | MOHE |
| | 1.3.4 Deepen and expand the shift to primary health care and reduce reliance on long-stay hospital care | Upgrade primary health care facilities | 2009 - 2015 | MOHE<br>Private sector NGOs<br>CBOs |
| | | Introduce a policy enabling support to primary health care including such areas as mental health , oral health and the provision of emergency contraceptive pills in health centres | 2010 - 2012 | MOHE<br>NFPB |
| | | Rationalize the service times in health centres | 2009 - onwards | MOHE |
| | | Expand and improve integration of family planning , maternal and child health, sexual and reproductive and HIV/AIDS into primary health care | 2009 - 2013 | MOHE<br>NFPB |
| | 1.3.5 Ensure the effectiveness of the care pathway | Ensure that the care pathway is defined | 2010 - 2011 | MOHE |
| 1.4 The physical environment in Jamaica is healthy and sustains the health of the population (National Strategy 1-9) | 1.4.1 Create appropriate frameworks to strengthen health security | Review & enforce existing and establish appropriate initiatives, policies, & regulations to support a healthy environment & living conditions | 2010 - 2013 | Cabinet Office<br>OPM<br>Bureau of Standards |
| | | Provide policy guidelines | Ongoing | MOHE |
| | 1.4.2 Identify and assess the linkages between the health of Jamaicans and | | | MOHE<br>Environmental Organizations |

| OUTCOMES | STRATEGIES | ACTIONS | TIME FRAME | RESPONSIBILITY |
|---|---|---|---|---|
| | the state of the environment, and define appropriate long-term strategies to anticipate changing environmental conditions | | | |
| | 1.4.3 Generate and sustain action across sectors to modify environmental determinants of health | Collaborate with relevant agencies and institutions | 2010 onwards | MOHE<br>Environmental Organizations<br>Other Private and Public Sector agencies |
| | 1.4.4 Infuse climate change issues into the National Health Policy | | | MOHE<br>Environmental Organizations |
| 1.5 The national food policy is supported (supports National Strategy 1-8) | 1.5.1 Design food policy from a nutrition /health perspective and support the production of safe foods | Reinforce the national infant feeding policy | 2010 onwards | MOHE<br>MOE<br>MOA |
| | | Design a public information campaign | 2010 - 2011 | MOHE |
| **GOAL 2: HIGH QUALITY FACILITIES FOR HEALTH SERVICES DELIVERY IN JAMAICA** | | | | |
| 2.1 The quality of the health infrastructure is high and works efficiently (supporting National Strategy 1-5) | 2.1.1 Establish standards and ensure that they are observed in the construction and maintenance of health facilities (with emphasis on health centres) | Ensure that appropriate policies and guidelines are established | 2010 - 2012 | MOHE |
| | | Ensure that buildings meet established standards | 2009 - 2030 | MOHE |
| | | Ensure that maintenance policies are observed | Ongoing | MOHE |
| | | | | |
| | 2.1.2 Ensure the provision and equitable access to appropriate and cost effective health technology including equipment | Institute a framework for equitably allocating technology including equipment and for providing associated logistical support | 2010 - 2011 | MOHE |
| | 2.1.3 Mainstream health technology assessment | Develop and implement a mechanism for continuing assessment and acquisition of appropriate technology at all levels of the public health delivery system | 2011-2012 | MOHE |
| | 2.1.4 Ensure the provision of an efficient and | Develop and implement a system for the acquisition, | 2010 | MOHE |

| OUTCOMES | STRATEGIES | ACTIONS | TIME FRAME | RESPONSIBILITY |
|---|---|---|---|---|
| | appropriate fleet of vehicles | appropriate allocation and maintenance of motor vehicles | | |
| | 2.1.5 Introduce centres of excellence at all levels and in all areas of the health system | Establish fully resourced centres and utilize modalities such as health tourism as a means of financing them | 2014 - 2030 | MOHE<br>MOT<br>JTB |
| | 2.1.6 Ensure that supplies are of adequate quality and quantity to meet the needs of the public health system | Enforce the regulations governing the supply of pharmaceuticals | 2010 - onwards | MOHE<br>Other relevant authorities |
| | | Develop a mechanism to continually assess the level of supplies and demand for pharmaceuticals and ensure adequate supplies and effective allocation of pharmaceuticals throughout the health system as needed | 2011 -2012 | MOHE |
| | | Continually monitor the level of medical sundries to ensure that adequate quantities are maintained to meet the needs of the health system | Ongoing | MOHE |
| 2.2 Decision making is supported by a national Health Information System (supporting National Strategy 1-5) | 2.2.1 Integrate health care and social protection systems | Collaborate with the Ministry of Labour and Social Security to develop a system for sharing information and cross referencing common data points | 2010 - 2011 | MOHE<br>MLSS |
| | 2.2.2 Formulate and implement a national health Information policy and regulatory framework to guide stakeholder participation | Undertake assessment to determine scope of data needs and identify stakeholders | 2011 | MOHE |
| | | Undertake stakeholder consultations to develop policy | 2011 - 2013 | MOHE<br>Stakeholders |
| | | Develop the policy through stakeholder working group | 2013 -2014 | MOHE<br>Stakeholders |
| | | Formulate and implement the National Health Information System | 2009-2010 | MOHE |
| | 2.2.3 Promote the use and application of information in health care management and delivery | Develop the National Health Information System | 2009 - 2011 | MOHE |
| | | Establish the Essential National Health Research Committee (ENHRC) | | MOHE |
| | | | | |

| OUTCOMES | STRATEGIES | ACTIONS | TIME FRAME | RESPONSIBILITY |
|---|---|---|---|---|
| **GOAL 3: A CADRE OF WORLD-CLASS HUMAN RESOURCES FOR THE HEALTH SERVICES** | | | | |
| 3.1 Staffing needs are adequately addressed (National Strategy 1-6) | 3.1.1 Review the required competencies for the health sector and establish and implement a Human Resources Strategic Plan to ensure a sustainable supply of skills and competencies for the sector | Create partnerships with training and other relevant institutions | 2010 - 2011 | MOHE |
| | | Organize job audits consistent with organizational development needs | 2011 | |
| | | Review the competencies and skills in the health sector | 2010 - 2012 | MOHE |
| | | Revise training programmes to align with market trends and health sector needs | 2012 - 2015 | MOHE<br>Health Training institutions |
| | | Establish the Caribbean Centre of Excellence Jamaica | | MOHE |
| | | Establish the Need-Based Human Resource in Health Project | | MOHE |
| | 3.1.2 Create flexibilities in HR recruitment, placement and decision making | Apply skills mix deployment and task shifting of human resources for maximum efficiencies | 2010 - onwards | MOHE |
| | 3.1.3 Establish a system to manage the impact of migration of critical health care personnel | Design and implement a system to recover the cost of losses to the health sector due to migration | 2010-2011 | MOHE<br>MFPS |
| | | Implement a plan for recruitment and retention of staff (including managed migration) | 2011/12 | MOHE |
| 3.2 The level and quality of outputs of staff are high (National Strategy 1-6) | 3.2.1 Strengthen the performance based management system | Deepen and extend the performance based management culture to include all categories of staff | 2010 onwards | MOHE<br>Trade Unions |
| | | Advocate for, and utilize HIS for enhancing staff accountability and performance | 2011 - onwards | MOHE<br>Trade Unions |
| | | Implement results based HR management system | 2011 - onwards | MOHE |
| | | Implement a system of peer reviews | 2011 - onwards | MOHE<br>Trade unions |
| **GOAL 4: WORLD-CLASS AND ACCESSIBLE HEALTH SERVICE DELIVERY** | | | | |
| 4.1 The Health | 4.1.1 Strengthen the policy | Review policies and | 2010 - 2011 | MOHE |

| OUTCOMES | STRATEGIES | ACTIONS | TIME FRAME | RESPONSIBILITY |
|---|---|---|---|---|
| Sector is effectively governed Supports National Strategy 1-7 | and regulatory framework of the health sector to address issues such as customer service , equity, human rights, delivery guidelines, research etc. | programmes and the regulatory framework to ensure that they are consistent with the legal and ethical obligations | | |
| | | Ensure that international guidelines and requirements are relevant to the local context and are observed | 2010 -2011 | MOHE |
| | 4.1.2 Facilitate social participation in health care delivery | Introduce partnerships and other similar mechanisms for including wider societal participation in the delivery and governance of the health sector | 2012 - onwards | MOHE |
| | | | | |
| | 4.1.3 Modify/develop the regulatory framework for optimal health care | Review service level agreements to conform to the regulatory framework underpinning health care services | 2011 - 2012 | MOHE |
| | | | | |
| | 4.1.4 Foster public-private partnerships in financing health care | Develop a policy and guidelines to facilitate transparent and efficient collaboration | 2010 - onwards | MOHE<br>Various private sector entities |
| | | | | |
| | 4.1.5 Strengthen existing programmes to improve and facilitate access to health care (e.g. National Health Fund, NI GOLD) | Review programmes to explore and introduce various options for expanding programmes and widening access | 2010 - 2015 | MOHE<br>MFPS |
| | | | | |
| | 4.1.6 Maintain and enforce the ethical dimensions that inform local policies and programmes | Facilitate agreement on the local core values of the Jamaican people that influence programmes and policies and ensure their infusion into health policies and programmes | 2011 - ongoing | MOHE<br>MICYS |
| **GOAL 5: SUSTAINABLE, EQUITABLE , EFFICIENT AND EFFECTIVE PUBLIC HEALTH FINANCING ACCESSIBLE BY ALL** | | | | |
| 5.1 The health system is adequately financed | 5.1.1 Establish a sustainable financing mechanism for the public health system | Establish a mechanism for investigating various financing options and making recommendations | 2010 - 2011 | MOHE<br>MFPS |

| OUTCOMES | STRATEGIES | ACTIONS | TIME FRAME | RESPONSIBILITY |
|---|---|---|---|---|
| (supports National Strategy 1-10) | 5.1.2 Eliminate catastrophic health costs to citizens | Review the role of private health financing and introduce national health insurance to cover those without health insurance | 2015 | MOHE<br>MFPS<br>Cabinet<br>OPM |
| | | Define and deliver a minimum health care service package for all and remove out of pocket payment for the minimum package | 2008 - onward | MOHE<br>Cabinet |
| | | Foster public/private partnership in financing health care | 2010 - onwards | MOHE<br>Private sector |
| | | Harmonize/integrate health care and social protection systems | 2012 - 2015 | MOHE<br>MLSS |
| | | Promote and facilitate access to available health insurance (NHF, NIGold, JADEP) for high risk/vulnerable | Ongoing | MOHE<br>MLSS |
| | 5.1.3 Develop allocation – allocative efficiencies | Review and strengthen the management and administration of the NHF to enhance its social protection mandate | 2010 - 2013 | MOHE |
| | | Design insurance schemes | See 5.1.2, action 1 | MOHE<br>MFPS |
| | | Demonstrate allocative efficiencies for budgeting | 2010 - onwards | MOHE |
| | | Provide incentives for private investment in health | 2011 - onwards | MOHE<br>MFPS<br>OPM<br>Cabinet |
| | | Expand the contribution to national insurance/social protection funds | 2011 - onwards | MOHE<br>MLSS |
| | 5.1.4 Optimize benefits from available resources | Rationalize/and manage all funding streams for improved targeting | 2011 - onwards | MOHE<br>MFPS |
| | | Apply equity considerations (disease burden, geographic, vulnerability) in decisions relating to resource allocation | 2010 - onwards | MOHE |
| | | Use data on service utilization gleaned from National Health Information System (NHIS) to inform financial planning and | 2011 - onwards | MOHE |

| OUTCOMES | STRATEGIES | ACTIONS | TIME FRAME | RESPONSIBILITY |
|---|---|---|---|---|
| | | allocation | | |
| | 5.1.5 Strengthen the information systems on financing and expenditure to make them reliable and comparable by facility or region | Integrate budget planning and evaluation processes/programme budgeting | 2010 - onwards | MOHE |
| | | Advocate for and ensure that the NHIS includes an integrated patient care – financial management system | 2012 - onwards | MOHE |
| | | Improve capabilities for costing services, expenditure reporting and budgeting at all levels of the health system | 2011 - 2014 | MOHE |

# 6. MONITORING & EVALUATION FRAMEWORK FOR THE HEALTH SECTOR

## Institutional Arrangements

A number of institutions and agencies, including those identified below will be involved in the monitoring and evaluation framework for the National Development Plan and the Health Sector Plan.

1. **Parliament**: The Vision 2030 Jamaica Annual Progress Report will be presented to the Parliament for deliberations and discussion.

2. The **Economic Development Committee (EDC)** is a committee of Cabinet chaired by the Prime Minister. The Committee will review progress and emerging policy implications on the implementation of Vision 2030 Jamaica and the relevant sector plans.

3. The **Vision 2030 Jamaica Technical Monitoring Committee (TMC)**, or Steering Committee, is to be chaired by the Office of the Prime Minister and will provide oversight for the technical coordination and monitoring of the Plan and report on the progress of implementation.

4. The **Vision 2030 Jamaica Technical Secretariat** to be institutionalized within the PIOJ will play a leading role in coordinating implementation, analyzing social and economic data and information, consolidating sectoral information into comprehensive reports on Vision 2030 Jamaica's achievements and results, maintaining liaisons with sectoral focal points in MDAs, and supporting the establishment and operation of Thematic Working Groups.

5. **Ministries, Departments and Agencies (MDAs)** represent very important bodies within the implementation, monitoring and evaluation system. They are the Sectoral Focal Points that will provide data/information on a timely basis on the selected sector indicators and action plans, and be responsible for the timely preparation of sector reports that will feed into the Vision 2030 Jamaica Annual Progress Report. For the Health Sector Plan, the main MDAs comprising the relevant Sectoral Focal Point will include the Ministry of Health and Environment , the Ministry, the Ministry of Finance and Planning, The Office of Disaster Preparedness and Emergency Management (ODPEM) the Bureau of Standards and various NGOs, CBOs, FBOs and Private Sector entities and practitioners.

6. **Thematic Working Groups are** consultative bodies aimed at providing multi-stakeholder participation in improving the coordination, planning, implementation and monitoring of programmes and projects relevant to the NDP and sector plans, including the Health Sector Plan. TWGs will be chaired

by Permanent Secretaries or senior Government officials and shall comprise technical representatives of MDAs, National Focal Points, the private sector, Civil Society Organizations and International Development Partners. TWGs will meet a minimum of twice annually.

## Indicator Framework and Data Sources

Appropriate indicators are the basic building blocks of monitoring and evaluation systems. A series of results-based monitoring policy matrices will be used to monitor and track progress towards achieving the targets for the NDP and sector plans, including the Health Sector Plan. The performance monitoring and evaluation framework will be heavily dependent on line/sector ministries for quality and timely sectoral data and monitoring progress.

The results-based performance matrices at the national and sector levels comprise:

- At the national level, 60 proposed indicators aligned to the 15 National Outcomes
- At the sector level, a range of proposed indicators aligned to the sector goals and outcomes
- Baseline values for 2007 or the most recent past year
- Targets which outline the proposed values for the national and sector indicators for the years 2012, 2015 and 2030
- Data sources which identify the MDAs or institutions that are primarily responsible for the collection of data to measure and report on national and sector indicators
- Sources of targets
- Links to existing local and international monitoring frameworks such as the MDGs

Some gaps still exist within the performance matrix and a process of review to validate the proposed indicators and targets is being undertaken. This process is very technical

and time consuming and requires significant cooperation and support from stakeholders and partners. The performance monitoring and evaluation framework will be heavily dependent on ministries for quality and timely sectoral data and monitoring progress. The system will benefit from our existing and relatively large and reliable statistical databases within the Statistical Institute of Jamaica (STATIN) and the PIOJ.

## Reporting

The timely preparation and submission of progress reports and other monitoring and evaluation outputs form an integral part of the monitoring process.

The main reports/outputs of the performance monitoring system are listed below.

1. **The Vision 2030 Jamaica Annual Progress Report** will be the main output of the performance monitoring and evaluation system.

2. **The annual sectoral reports** compiled by the Sectoral Focal Points for submission to the Vision 2030 Jamaica Technical Monitoring Committee. These will be integrated into the Annual Progress Report.

3. **Other products** of the performance monitoring system include issues/sector briefs and research reports.

## Capacity Development

There is recognition that building and strengthening technical and institutional capacity for the effective implementation, monitoring and evaluation of the NDP and the Health Sector Plan is critical for success. This calls for substantial resources, partnership and long-term commitment to training MDA staff. Training needs will have to be identified at all levels of the system; a reorientation of work processes, instruments, procedures and systems development will have to be undertaken; and staffing and institutional arrangements will need to be put in place. Partnership with the Management Institute

for National Development (MIND) and other institutions will also be required to provide training to public sector staff and others in critical areas such as results-based project management and analysis, monitoring and evaluation, and data management.

## LIST OF ACRONYMS

| | |
|---|---|
| **AIDS** | Acquired Immuno-Deficiency Syndrome |
| **CAM** | Complementary and Alternative Medicine |
| **CAT** | Computerized Axial Technology |
| **CDA** | Child Development Agency |
| **CSME** | CARICOM Single Market and Economy |
| **EDC** | Economic Development Council |
| **EMS** | Emergency Medical Services |
| **ESSJ** | Economic and Social Survey Jamaica |
| **GDP** | Gross Domestic Product |
| **GNI** | Gross National Income |
| **GOJ** | Government of Jamaica |
| **HCL** | Health Corporation Limited |
| **HIS** | Health Information System |

| | |
|---|---|
| **HIV** | Human Immuno-Deficiency Virus |
| **HR** | Human Resources |
| **HSR** | Health Sector Reform |
| **ICT** | Information Communication Technology |
| **IDP** | International Development Partner |
| **IMR** | Infant Mortality Rate |
| **JADEP** | Jamaica Drugs for the Elderly Programme |
| **JSLC** | Jamaica Survey of Living Conditions |
| **KMA** | Kingston Metropolitan Region |
| **LE** | Life Expectancy |
| **MAP** | Macro-economic Adjustment Policies |
| **MDA** | Ministries, Departments and Agencies |
| **MDG** | Millennium Development Goal |
| **MIND** | Management Institute for National Development |
| **MMR** | Maternal Mortality Rate |
| **MOHE** | Ministry of Health and Environment |
| **MRI** | Magnetic Resonance Imaging |
| **MVA** | Motor vehicle accident |
| **NDP** | National Development Plan |
| **NERHA** | North East Regional Health Authority |
| **NGO** | Non-Government Organisation |
| **NHF** | National Health Fund |
| **NHIS** | National Health Information System |
| **NIS** | National Insurance Scheme |
| **NPC** | National Planning Council |
| **PAS** | Patient Administration System |
| **PHC** | Primary Health Care |
| **PIOJ** | Planning Institute of Jamaica |
| **RHA** | Regional Health Authority |
| **SDOH** | Social Determinants of Health |
| **SERHA** | South East Regional Health Authority |
| **SRHA** | Southern Regional Health Authority |
| **TM** | Traditional Medicine |
| **TMC** | Thematic Monitoring Committee |
| **TWC** | Thematic Working Group |
| **UNESCO** | United Nations Educational, Scientific and Cultural Organization |
| **UNFPA** | United Nations Population Fund |
| **UTECH** | University of Technology |
| **VRI** | Violence related injury |
| **WHO** | World Health Organisation |
| **WRHA** | Western Regional Health Authority |

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## APPENDIX 1

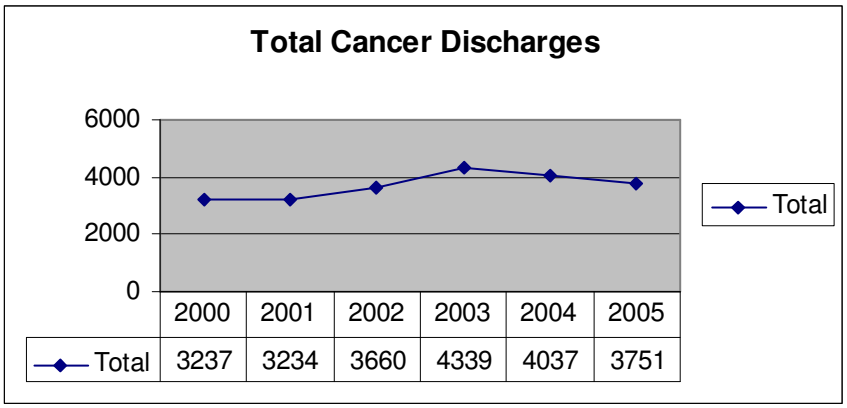
## Various Health Data

### Ten (10) Leading Causes of Death

| Cause of death | Years | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1970 | 1977 | 1980 | 1985 | 1990 | 1995 | 2000 | 2004 | 2005 |
| **Diseases of the circulatory system** | 4478 (1) | 4933 (1) | 4,531 (1) | 5352 (1) | 4774 (1) | 4462 (1) | 4842 (1) | 4836 (1) | 5063 (1) |
| **Neoplasms** | 1478 | 1586 (2) | 1512 (2) | 2173 | 2000 (2) | 2189 | 2721 (2) | 2798 (2) | 2969 |

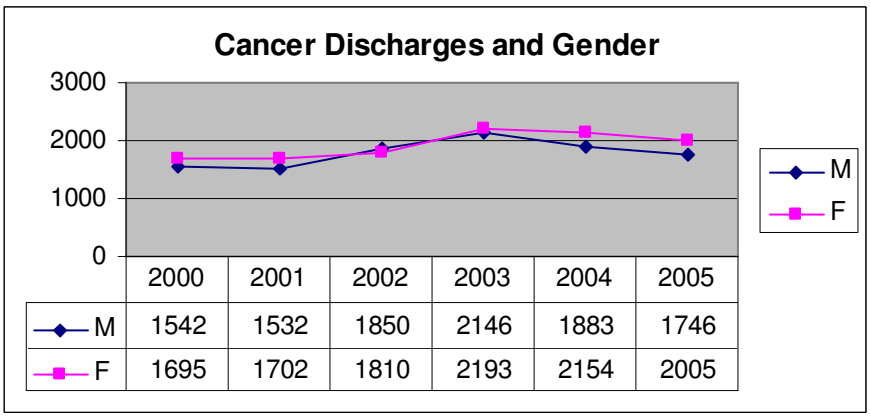
| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | (2) | | | (2) | | (2) | | | (2) |
| **Accidents and Injuries-Accidents, poisoning and violence (external cause)** | 453 (8) | 389 (6) | 352 (7) | 549 (7) | 197 (9) | 139 (8) | 747 (5) | 2137 (3) | 1034 (5) |
| **Nutrition endocrine diseases** | 1112 (5) | 776 (4) | 665 (5) | 1010 (3) | 1515 (3) | 1594 (3) | 1817 (3) | 1872 (4) | 2066 (3) |
| **I1-Diseases of the respiratory system** | 1336 (3) | 1030 (3) | 699 (4) | 870 (5) | 723 (4) | 750 (5) | 974 (4) | 967 (5) | 1056 (4) |
| **Infectious and parasitic diseases-intestinal diseases** | 1267 (4) | 685 (5) | 543 (6) | 714 (6) | 382 (6) | 297 (6) | 722 (6) | 714 (6) | 765 (6) |
| **Diseases of the digestive system** | 463 (7) | 376 (7) | 778 (3) | 930 (4) | 713 (5) | 654 (4) | 383 (7) | 374 (7) | 433 (7) |
| **Signs, symptoms and ill-defined conditions** | 766 | 1686 | 1720 | 1397 | 2077 | 721 | 2111 | 370 | 294 |
| **Diseases of the genitourinary system** | 354 (9) | 344 (9) | 40 | 48 | 23 | 66 | 356 (8) | 306 (8) | 305 (9) |
| **Neuro-psychiatric conditions** | 342 (10) | 354 (8) | 303 (8) | 361 (8) | 180 (9) | 198 (7) | 279 (9) | 294 (9) | 311 (8) |
| **Diseases of blood and blood forming organs** | 111 | 82 | 92 | 105 | 40 | 109 (9) | 212 (10) | 193 (10) | 254 (10) |
| **Diseases of the skin and subcutaneous** | 58 | 52 | 87 | 93 | 83 (10) | 92 | 142 | 141 | 135(11) |
| **Diseases of the musculo-skeletal** | 44 | 36 | 38 | 63 | 12 | 51 | 151 | 110 | 95(12) |
| **Congenital Malformation** | 103 | 49 | 114 (10) | 138 (10) | 69 | 25 | 13 | 19 | 0 |
| **Obstetric** | 68 | 32 | 25 | 29 | 7 | 6 | 21 | 4 | 0 |
| **Perinatal** | 489 (6) | 229 (10) | 217 (9) | 223 (9) | 336 (7) | 97 (10) | 11 | 1 | 0 |
| **Diseases of the eye and ear** | 3 | 0 | 1 | 1 | 1 | 6 | 0 | | 0 |

**Total Cancer Discharges from Hospitals (2000-2005)**




**Source: Hospital Monthly Statistical Reports (2000-2005)**

**Cancer Discharges from Hospitals by Gender (2000-2005**




**Source: Hospital Monthly Statistical Reports (2000-2005)**

## Appendix 2

## Expenditure on Infrastructure and Equipment of Hospitals and Health Centres

**Assessment of Hospitals and Health Centres**

| Health Facilities | Infrastructure | Equipment | Total |
|---|---|---|---|
| Sav la mar | 48,100,000 | 50,140,000 | 98,240,000 |
| CRH | 128,556,000 | 36,390,000 | 164,946,000 |
| Annotto Bay Hospital | 200,000,000 | 20,000,000 | 220,000,000 |
| St Ann's Bay | 40,000,000 | 30,238,800 | 70,238,800 |

| | | | |
|---|---|---|---|
| Bustamante | 120,000,000 | 10,000,000 | 130,000,000 |
| Spanish Town | | 20,000,000 | 20,000,000 |
| UHWI | 300,000,000 | 207,000,000 | 507,000,000 |
| May Pen | 87,855,000 | 7,244,000 | 95,099,000 |
| Mandeville | 341,408,000 | 22,750,000 | 364,158,000 |
| KPH | 300,000,000 | 50,000,000 | 350,000,000 |
| Lionel Town | 40,000,000 | 10,000,000 | 50,000,000 |
| Percy Junor | 10,000,000 | 5,000,000 | 15,000,000 |
| Black River | 30,000,000 | 10,000,000 | 40,000,000 |
| Noel Holmes | 20,000,000 | 5,000,000 | 25,000,000 |
| Port Maria | 10,000,000 | 5,000,000 | 15,000,000 |
| Port Antonio | 20,000,000 | 5,000,000 | 25,000,000 |
| Princess Margaret | 10,000,000 | 5,000,000 | 15,000,000 |
| 300 Health Centres | 300,000,000 | 150,000,000 | 450,000,000 |
| | **J$ 2,005,919,000** | **J$ 648,762,800** | **J$ 2,654,681,800** |

**Appendix 3**

**Analysis of Cost of Drugs and Sundries for the public health sector for 2008/2009**

**Analysis of Cost of Drugs and Sundries for the public health sector for 2008/2009**

| | US$ | J$ |
|---|---|---|
| Value of 18-month tender awards | | |
| Drugs | 15,503,619 | 1,116,260,568 |
| Sundries | 3,992,518 | 287,461,296 |
| Total | 19,496,137 | 1,403,721,864 |

| | | |
|---|---|---|
| | | - |
| Convert to Annual value of drugs and sundries | 12,997,425 | 935,814,576 |
| HCL Service level to RHAs | 79% | |
| | | - |
| Annual value of 79% service level to RHAs | 12,997,425 | 935,814,576 |
| | | - |
| Annual vale of 100% service level to RHAs | 16,452,436 | 1,184,575,413 |
| Add: Annual Value of X-Ray films | 531,180 | 38,244,960 |
| Add: Annual value of sutures | 1,387,331 | 99,887,832 |
| Total Cost of drugs and sundries | 18,370,947 | 1,322,708,205 |
| | | - |
| Administrative cost to purchase, store and distribute drugs and sundries | | 396,812,529 |
| Total Cost to RHAs for drugs and sundries | | **J$ 1,719,520,734** |

**Appendix 4**

**Post Occupancy in the Public Health Care System (Jamaica),Cost of filling vacancies plus additional critical staff**

| Category | Total RHAs | |
|---|---|---|

| | Cadre | In Post | Vacancy | Excess Staff/Posts that Need to Be Established Now | Additional Staff | Total Additional Staff Needed and Vacancies | Cost of Salaries to Fill vacancies and Employ Additional Staff |
|---|---|---|---|---|---|---|---|
| Doctors - in Hospital | 408 | 603 | 0 | 195 | 195 | 195 | 263,318,055 |
| Doctors - in Primary Care | 107 | 112 | 9 | 14 | 14 | 23 | 31,058,027 |
| Dentist | 61 | 49 | 12 | 0 | 0 | 12 | 15,900,360 |
| Dental Nurse | 138 | 129 | 9 | 0 | 0 | 9 | 4,670,145 |
| Health Educator | 33 | 30 | 3 | 0 | 0 | 3 | 1,877,391 |
| Family Nurse Practitioner | 78 | 65 | 15 | 2 | 2 | 17 | 21,075,155 |
| Nurse Anaesthetist | 25 | 29 | 1 | 5 | 5 | 6 | 5,922,948 |
| Psychiatric Nurse Practitioner/ Mental Health Officer | 22 | 36 | 3 | 6 | 17 | 20 | 12,515,940 |
| Public Health Nurse | 231 | 160 | 71 | 0 | 0 | 71 | 75,413,218 |
| Registered Nurse | 2229 | 1642 | 587 | 0 | 0 | 587 | 411,367,839 |
| Community Health Aide | 563 | 736 | 0 | 173 | 172 | 172 | 62,321,964 |
| Public Health Inspector | 283 | 239 | 48 | 4 | 19 | 67 | 41,631,857 |
| Medical Technologist | 65 | 44 | 33 | 12 | 13 | 46 | 29,333,832 |
| Diagnostic Radiographer | 48 | 45 | 5 | 2 | 2 | 7 | 3,496,388 |
| Therapeutic Radiographer | 10 | 3 | 7 | 0 | 0 | 7 | 3,496,388 |
| Nutritionist | 8 | 8 | 1 | 1 | 38 | 39 | 19,479,876 |
| Pharmacist | 131 | 67 | 64 | 0 | 0 | 64 | 44,101,248 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Physiotherapist | 32 | 36 | 3 | 3 | 3 | 6 | 2,996,904 |
| Health Records Personnel | 137 | 368 | 0 | 231 | 194 | 194 | 80,582,556 |
| Biomedical Engineer | 0 | 1 | 0 | 1 | 17 | 17 | 25,500,000 |
| **Totals** | **4,609** | **4,402** | **871** | **649** | **691** | **1,562** | **J$ 1,156,060,091** |

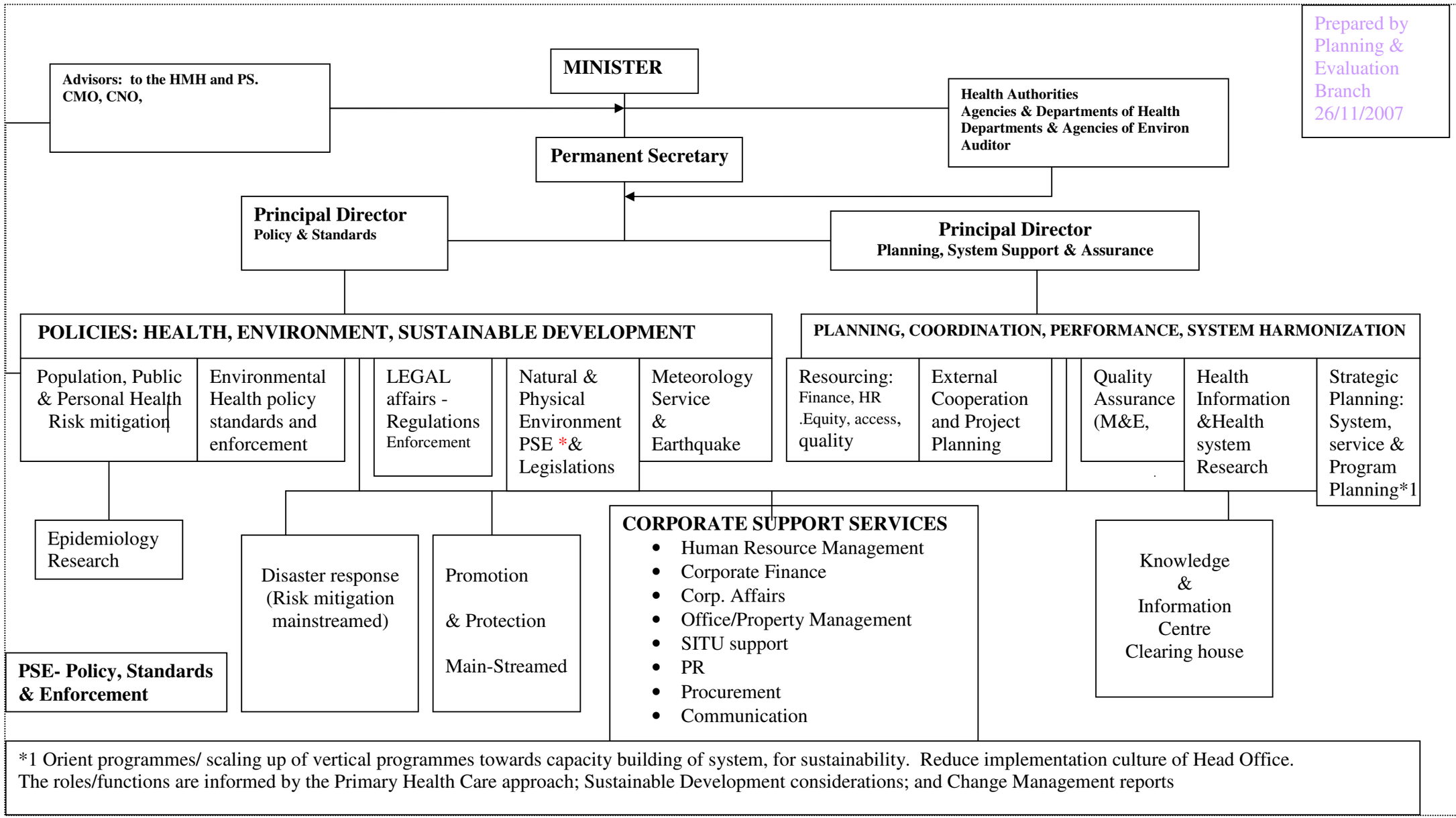
**APPENDIX 5**

**PLANNING. PERFORMANCE & DEVELOPMENT PORTFOLIO & SERVICES**

| | **RESOURCING** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **ENVIRONMENTAL POLICY NATURA** | **Health Policy** | **Planning** | **Performance, Monitoring & Evaluation** | **Health Information (HIS)** | **Service Quality Assurance** | **Project Financing** | **Infrastructure** | **Human resource** | **Health Financing** |
| | Intersectoral policies | National Strategic plans | Design M&E framework & M&E database for monitoring & evaluating outcomes | -HIS/Health Informatics | Independence from technical services/programs needed | Project Finance Monitoring | Technology assessments | HR audits and planning and development | Health Insurance |
| | Health service policy | MOH and Service Strategic/Corporate Plan. | Research/data analysis on system performance | Health Records Management (and patient data capture) | Technical assessments Standards development | Infrastructure development projects Special Projects | Pharmaceutical and medical supplies | New skills in health Career paths Training | Designing and costing of Essential health package |
| | Cabinet submissions | Operational plans | Provide reports/ analyses on performance-for policy & planning | Coding of diagnoses | Audits (team drawn across services) | | Diagnostic equipment planning – supply, maintenance, rationalization | Competencies development | Provider Payment (RHA, Private ) -Perverse incentives monitoring |
| | Public private partnerships | Budgets | Plan for Region M&E capacity building and analysis | Collate information, validate accuracy, analyse data and generate reports | Audit Operational processes | IDP liaison | Laboratory services | Long term HR sustainability | Commissioning |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **L** | Financing policy<br>- Fees<br>- Insurance | Build HIS and analyse data. (Application of health information to decision making | Support region in designing M& E system for performance monitoring and reporting | Meet data /information needs of stakeholders | Focus is on Service quality | Externally financed projects and programmes and budgetary support | Physical facilities for Primary, secondary and support services | Standards of HR training and retraining | Service costing<br>Economic analysis<br>Technology Assessment |
| | | | Plan & Oversee Evaluations | Central repository for system data/information | | | Information Technology support | | |
| | Consultations | Financing for the strategic plan through IDP partnerships & programme | Research – to support planning and evaluation of policy & policy implementation | Support evidence based planning | Service standard (professional, service and client satisfaction) | Resource mobilization | Transportation services | Backward linkages with education sector | Design Health financing mechanisms for mobilizing resources |

# PORTFOLIO RESPOSIBILITIES OF THE MINSITRY OF HEALTH AND ENVIRONMENT – IN SUPPORT OF SUSTAINABLE HEALTH




*1 Orient programmes/ scaling up of vertical programmes towards capacity building of system, for sustainability. Reduce implementation culture of Head Office.
The roles/functions are informed by the Primary Health Care approach; Sustainable Development considerations; and Change Management reports