Monetary Fund Country Report No. 07/97 (Washington DC: International Monetary Fund), pp. 67–89.

Roache, S., 2007, "Public Investment and Growth in the Eastern Caribbean" International Monetary Fund Working Paper No. 07/124 (Washington DC: International Monetary Fund).

Veira, J., 2005, *National Insurance Services of St. Vincent and the Grenadines: Actuarial Valuation as of January 1st 2005* (St. Vincent and the Grenadines: Board of the NIS of St. Vincent and the Grenadines).

VIII. Financing Universal Health Care: Lessons for the Eastern Caribbean and Beyond[57]

A. Introduction

1. **Given the special characteristics of health care provision and in response to economic development, an increasing number of Caribbean countries have either introduced or are actively considering the introduction of universal health care, primarily financed by government** (Tables VIII.1 and VIII.2). For example, given the high out-of pocket spending and inefficiencies in the current delivery system, St. Lucia has announced its intention to move towards universal health care, following in the footsteps of Antigua and Barbuda, which has had such a health system since the late 1970s. The St. Lucian proposal for universal health care entails the free provision to all residents of health services related to a specified list of common diseases. In the case of Antigua and Barbuda, the spending is financed by payroll contributions, while St. Lucia is considering a financing combination of budgetary support and higher general taxation.

2. **The rationales for public intervention in providing health care are related to the issues of public goods, externalities, and insurance failures** (Musgrove, 1996). Health financing goals—which include reducing inequality (by lowering out-of-pocket spending); preventing individuals from falling into poverty in the event of catastrophic medical expenses; and improving the health outcomes of the population by ensuring financial access of basic health services to all—are often cited as arguments supporting public intervention.

3. **This chapter provides an overview of health financing policy options for universal care in the ECCU and beyond.** It is intended to assist ECCU policymakers in the design, implementation, and evaluation of effective health financing reforms, based on the experience of other countries, taking into consideration the region's emerging demographic and epidemiological transition. The chapter finds that the optimal financing option is country-specific—depending on a country's economic, cultural, institutional, demographic and epidemiological characteristics, as well as political economy considerations—but there are some basic guidelines that need to be satisfied no matter which financing means is chosen. In particular, the financing option has to be: (i) domestically-based; (ii) sustainable; (iii) efficient; (iv) equitable; and (v) politically acceptable.

4. **Exploring appropriate means for the provision of universal health care is beyond the scope of this analysis.** However, the typical setting in countries with or considering universal health care involves the provision of services through public hospitals and/or private doctors who voluntarily participate in the universal health care scheme; while

[57] Prepared by Evridiki Tsounta.

all other services are provided by the private sector using supplemental private health insurance schemes (often co-financed with the employer). The latter services are provided by the public hospital, free of charge, only to the needy and the elderly.

5. **The shift in demographics and the trend towards noncommunicable chronic diseases (epidemiological transition) will exacerbate health spending in the Caribbean**. The ECCU will face significant aging in the next three decades; the number of people over the age of 60 is projected to almost double by 2035, from 9.5 percent of the population in 2005 to 17 percent in 2035 (see Figure VIII.1 and Chapter VII of this paper).[58] In addition, chronic diseases, such as cardiovascular illnesses, cancer and diabetes have become the main causes of death in the region (Figure VIII.2).[59] Aging, together with the increasing prevalence of chronic diseases, will have a large impact on health costs and thus implicitly and explicitly affect the appropriateness of the various health financing options.

B. Financing Options for Universal Health Care

6. **Health system reforms should be undertaken in the context of a government's available and projected "fiscal space."** In principle, the fiscal space in any country could increase through tax measures (tax increases or better tax administration), lower government spending, additional borrowing, and external financing (e.g., grants from donors).

7. **Health system reforms should be based solely on domestic sources of finance.** Disbursements of official development assistance (ODA) to the region have been disappointing in recent years, and ODA on health, in particular, is scarce since it is usually reserved for low-income countries (Figure VIII.3). Donor aid has also been unpredictable due to political and budgetary decisions by donors; administrative delays on the donor's side; and substantial bureaucratic procurement and reporting requirements that often result in lack of disbursements given noncompliance with agreed conditionalities (World Bank, 2006). Even if donor assistance is provided, the sustainability of the health system might be compromised if the country is not able to sustain the same level of services once donor funding ceases.

8. **Lowering other forms of government spending or accumulating debt to accommodate increasing health spending is neither popular nor advisable,** given: (i) the recurrent nature of health spending; (ii) the expected increase in health costs amid population aging and the epidemiological transition; and (iii) the already high debt level in many Caribbean islands (IMF, 2007).

---

[58] According to World Bank (2006), over the next 20 years, changes in population size and structure alone will increase total health spending needs by 47 percent in Latin American and the Caribbean.

[59] For example, St. Lucia has the highest prevalence of diabetes, in per capita terms, in the world.

9. **Universal health care is typically financed, at least in part, through taxation** (Figure VIII.4**)**. For example, general tax-based funding is used in the United Kingdom, Canada, Sweden, and Brazil, while mandatory income/social security contributions are used in Germany, Japan and Costa Rica. Many countries offer basic health services to a broader population that does not contribute using supplementary budget contributions. In practice a mix of health financing methods is adopted, whereby some basic services are universally provided—financed by general taxation or wage contributions—and the remaining private services are financed using private insurance or out-of-pocket spending. As noted in WHO (2003), the challenge is to develop the mix of financing methods best suited to national macroeconomic conditions, the socio-cultural environment and the disease burden. This requires a financing system that: generates adequate resources to finance the current and projected health needs; is equitable in the sense that resources are raised according to the ability to pay, while access to services is based on need; and is efficient by providing the best value for money.

C. General Taxation Versus Wage Contributions

10. **In this section we compare and contrast universal health care financing using general taxation (such as VATs) with financing using payroll/social security contributions**. According to IMF and World Bank (2005), taxes should be judged by the following five commonly-accepted criteria:

- *Revenue adequacy and stability.* The tax should raise a significant amount of revenue, be relatively stable, and be likely to grow over time.

- *Efficiency.* The tax should minimize economic distortions.

- *Equity.* The tax should treat different income groups fairly.

- *Ease of collection.* The tax should be simple to administer to keep costs at a minimum.

- *Political acceptability.* The tax should be transparent and its uses should be clearly defined so as to promote acceptability.

Revenue adequacy and stability

11. **The revenue potential from payroll contributions depends on the country's labor market conditions, existing payroll tax rates, and the size of the informal economy** (Figure VIII.5). While revenues from both general taxation and wage contributions rise with economic growth, evidence from Eastern European and Central Asian countries that have introduced universal health care indicate that growth is not a necessary and sufficient condition for revenue adequacy. These countries, characterized by a large informal sector, many self-employed and under-employed, and already feature high payroll tax rates, have failed to generate sufficient tax revenue (using payroll contributions) to finance universal

health care. For example, Kazakhstan abandoned universal coverage financed mostly via social security contributions in 1999, after disappointingly low revenue collections—only 40 percent of the expected revenue was actually collected (Langenbrunner, 2005). Tax avoidance by labor and small businesses and high levels of unemployment and self-employment were also cited for the low revenue generation in Russia, Albania and Romania (Langenbrunner, 2005). In addition, in countries where salaries are already a major source of taxation—in the form of income tax and unemployment insurance contributions—the potential for additional revenue-raising from payroll contributions to finance universal health care is limited (Normand and Weber, 1994).

12. **In general, experiences from many countries that rely on payroll contributions as a major source of health financing suggest that numerous conditions are needed for successful revenue generation**.[60] Strong economic growth is needed to raise sufficient revenues; a large formal economy assists in ensuring a reliable source of payroll contributions (Ensor and Thompson, 1998); strong tax administrative capacity to enforce collection; and reasonable contribution rates to finance health spending while providing incentives for the majority of the population to contribute.

13. **General taxation could better secure revenue adequacy.** General taxation, in the form of indirect taxes such as VATs and sales taxes, could ensure that a broader base is taxed, including the tourism sector and most of the informal sector.[61] VATs, for example, have already been introduced in the ECCU countries of Antigua and Barbuda, Dominica, and St. Vincent and the Grenadines, with tax yields and enforcement rates at higher levels than originally envisioned. Outside the region, some countries (for example, Ghana) have gone a step further and increased the VAT rate to finance universal health care.

Efficiency

14. **The broad-based nature of general taxation provides efficiency gains** (Coady et al., 2004). In contrast, payroll contributions have been found in the case of Latin American and Caribbean countries to raise tax evasion and reduce the size of the formal labor market (Baeza and Packard, forthcoming). World Bank (2006) also notes that payroll contributions raise labor costs and thus hinder economic growth, employment and competitiveness.

Equity

15. **While general taxes rely on a broad revenue base, they could be regressive.** For example, a VAT is typically regressive, since low-income people pay a higher percentage of

[60] Examples include Estonia, Czech Republic, Hungary, and Slovakia, and to a large extent, Argentina, Chile, and the Republic of Korea.

[61] The tourism sector in the ECCU is usually under-taxed, partly reflecting the presence of generous tax holidays.

their income in tax than high-income people. However, indirect taxes could be designed to be more progressive; for example, goods that are relatively important in the household budget of the poor (such as basic food and clothing) could be made exempt. In contrast, payroll contributions are at best as progressive as general taxation in financing universal health care (Normand and Busse, 2002).

Ease of collection

16. **Tax collection *per se* is easier using payroll contributions; however, issues related to informality must also be considered.** Payroll contributions are automatically deducted from employees' payrolls, which make their collection an easy proposition. However, in the case of the ECCU, collection could be hindered by the region's large informal economy, and significant self-employed and agriculture sectors, as evidenced by the case of Antigua and Barbuda (Vuletin, 2007). In addition, since incomes in the informal sector tend to be erratic, assessing them for payroll contributions would be particularly difficult (Normand and Weber, 1994). Spain and Iceland have shifted from social security contributions to general taxation to finance universal health care, in order to avoid these problems.

Political acceptability

17. **Payroll contributions are more politically acceptable than general taxation, since the latter is typically regressive.** However, the political acceptability of general taxation could be enhanced if there is a specific individual entitlement that accompanies the tax (that is, a benefit tax), such as in the case of Ghana with its higher VAT tax rate.

D. Preconditions for Successfully Financing Universal Health Care

18. **No matter the financing option chosen, several conditions are needed to ensure that the financing strategy is appropriate**.

- *Universal health care plans should be part of the government's medium- and long-term strategy.* The costs of implementing universal health care should be carefully evaluated, taking into account its increasing future needs stemming from population aging and the epidemiological transition. In addition, the health plan's cost should be incorporated into the medium-term expenditure framework, so as to ensure its current and future financial viability.

- *The financing of universal health care should be transparent.* This would gather the support of the population, particularly if the advantages of the system are pointed out to build consensus (Normand and Weber, 1994).

- *The informal sector should be tackled*, so that no matter which financing policy is used, all health beneficiaries pay according to their ability.

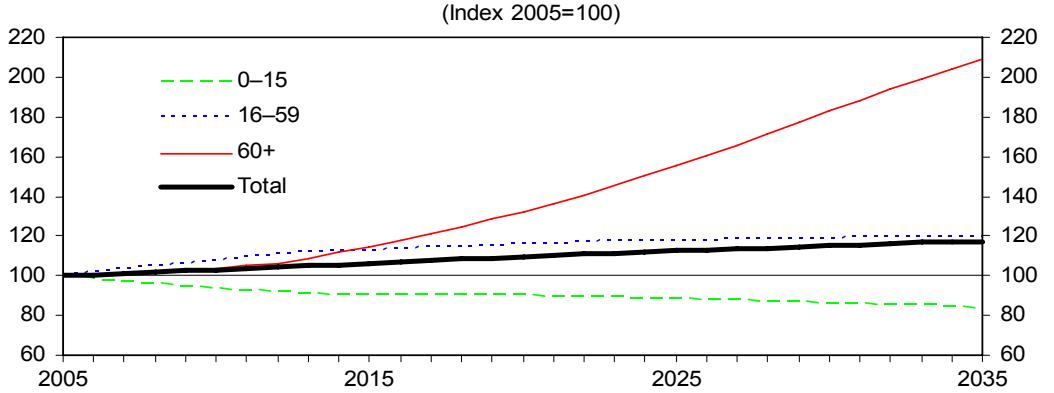
- *Tax administration should be sound,* so that the tax effort is translated into strong tax revenues.

E. Conclusions

19. **Prior to moving toward universal health care, a country needs to ensure that funding will be sustainable and commensurate with the long-term needs resulting from the epidemiological transition and population aging**. Relying on domestic revenues for the bulk of financing is a prerequisite, since most development assistance for health is focused on very low-income countries and even if present, its disbursement is usually erratic and short-lived (i.e., the country would need to sustain spending once aid flows cease).

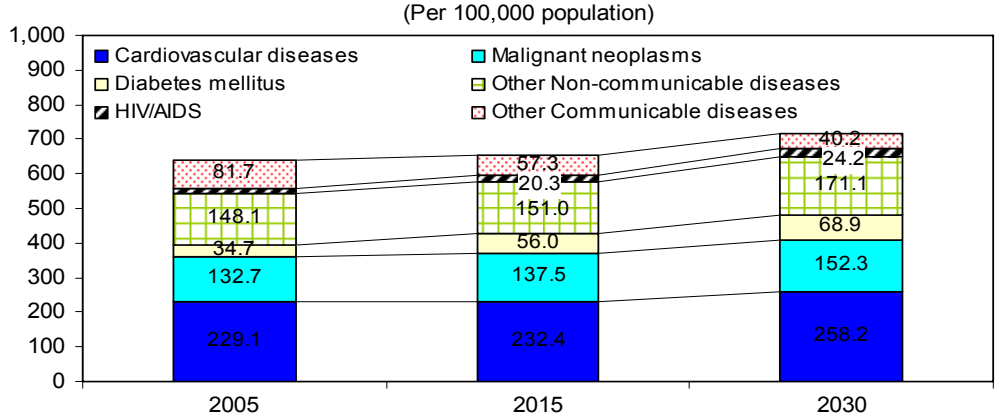
20. **There is no one-size-fits-all solution in deciding the appropriate manner in which to finance universal health care.** No matter which financing option is eventually adopted (financing by general taxation or payroll contributions), the system should be able to raise enough revenues to finance the current and long-term spending needs of the country. In addition, the appropriate financing strategy depends on the country's economic, cultural, institutional, demographic and epidemiological characteristics, as well as political economy considerations.

Figure VIII.1. ECCU: Population by Age Group, 2005–35
(Index 2005=100)



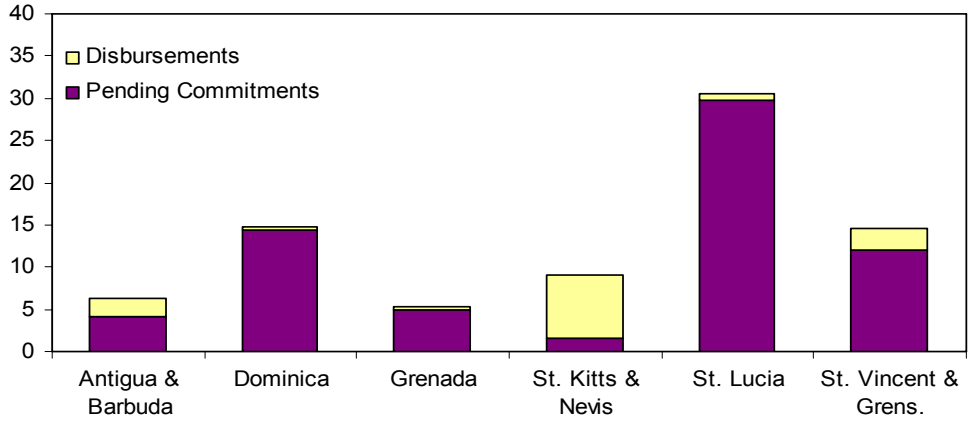
Sources: International Labor Statistics, Country authorities; and Fund staff calculations.

Figure VIII.2. Region of the Americas: Causes of Death, 2005–30
(Per 100,000 population)



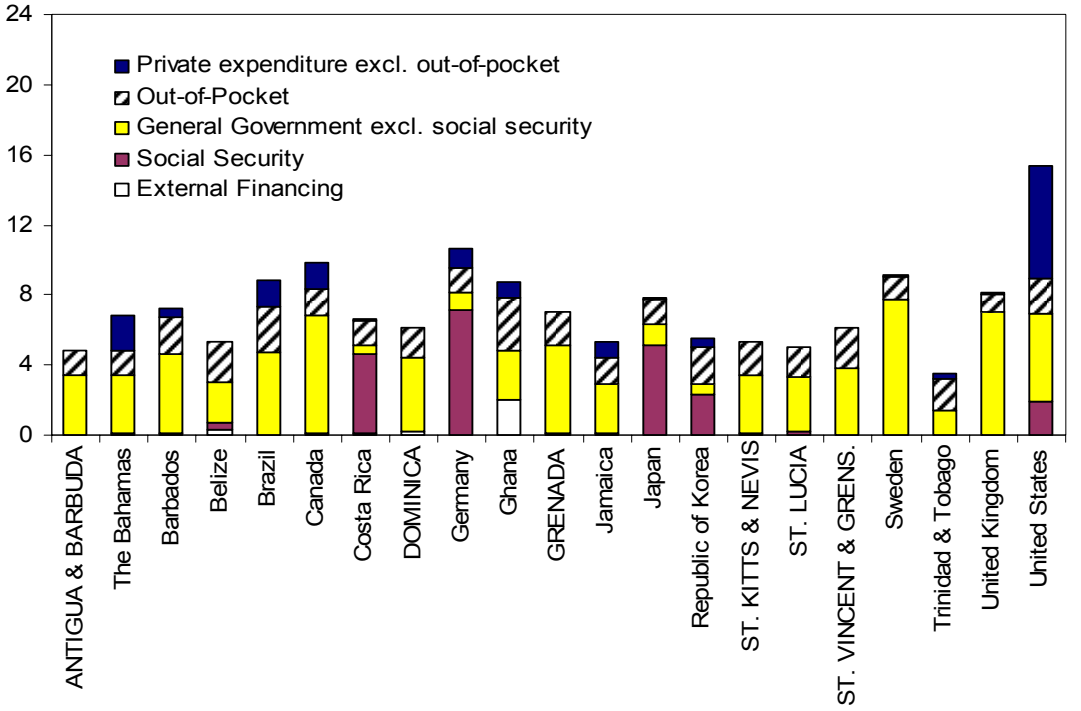
Source: World Health Organization.

Figure VIII.3. ECCU: Official Development Assistance for Health
(In millions of U.S. dollars at 2004 prices, total of 1973-2005)



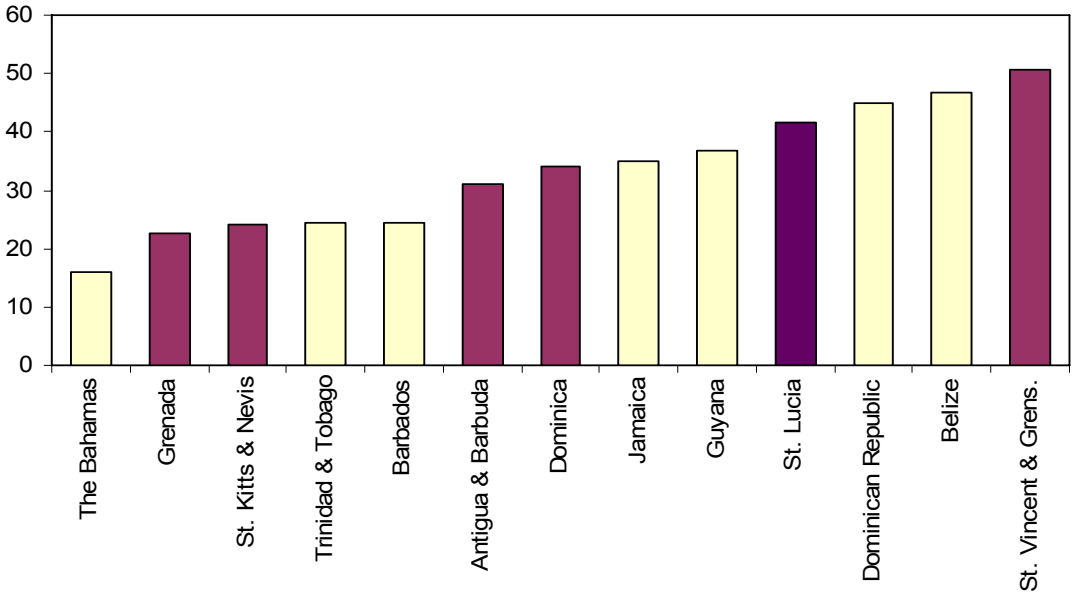
Source: OECD.

Figure VIII.4. Health Financing, 2004
(In Percent of GDP)



Source: World Health Organization.

Figure VII.5. Caribbean: Estimated Size of the Informal Economy, Early 2000s
(In percent of GDP)



Source: Vuletin (2007).

Table VIII.1. Selected Countries with Universal Health Care 1/

	Antigua & Barbuda (1978)	Bermuda (1971)	Cayman Islands (1997)	Suriname (1981)	Ghana (2004)
Coverage	All persons suffering from a list of nine chronic diseases.	All workers and unemployed spouses. Government pays for indigent, children, and the elderly.	All workers and dependents. Indigent covered by government through levy on worker's premiums.	All civil servants and dependents, and some voluntary insured (36 percent of population).	All residents. Government pays for the aged, poor and children of subscribers.
Package	Ambulatory care, IP, OP, overseas IP.	IP, OP, overseas IP.	Ambulatory care, IP, OP, overseas IP.	Ambulatory care, IP, OP, overseas IP.	…
Contribution	7 percent of wages up to a ceiling, shared equally between employee and employer.	Fixed price package adjusted annually (around 3 percent of income); shared by employee and employer.	Fixed price set by private companies after government's approval; shared by employee and employer.	9 percent of wages shared (4 percent employee, 5 percent government). Fixed price for voluntary insured.	2.5 percent national health insurance levy added to VAT; use 2.5 percent of wages from National Worker's Social Security; $0.66 monthly minimum subscription.
Service provision	Public, private and overseas facilities.	Public hospitals and overseas facilities.	Public, private and overseas facilities.	Public, private and overseas facilities.	Public hospitals
Key Issues	No collection from self-employed.	Growing burden on government.	Growing burden on government.	Outflows exceed inflows.	…

Source: Lalta et al. (2005)

1/ Numbers in parentheses indicate the year of introduction of universal health care.
Note: IP denotes inpatient care, and OP denotes outpatient care.

Table VIII.2. Selected Caribbean Countries Planning Universal Health Care Coverage 1/

	The Bahamas (2004)	Belize (2002)	St. Lucia (2004)	St. Vincent & Grens. (1998)	Jamaica (1997)	Trinidad & Tobago (1995)
Coverage	All residents.	All residents.	All residents.	All residents.	All residents.	All residents.
Package	IP, OP, ambulatory care, some overseas services.	IP, OP, ambulatory care, some overseas services.	IP, OP, drugs, some overseas services.	IP, OP, ambulatory care.	IP, OP, drugs, some overseas services.	IP, OP, ambulatory care, drugs, tests.
Contribution	Percentage of income; government subsidies for indigent, elderly, children.	5 percent of workers' income; shared by employee and employer; government subsidies for indigent and pensioners.	3.5–4 percent environmental levy on imports (excluding clothes and food). Estimated revenue: US$13 million.	9 percent of wages-shared by employee and employer; government subsidies for indigent.	Fixed price premium-shared by employee and employer; government subsidies for indigent.	10.1 percent of earnings-shared by employee and employer.
Service provision	Public and private hospitals.	Public and private hospitals.	Public and private hospitals.	Public and private hospitals.	Public and private hospitals.	Public and private hospitals.

Source: Lalta et al. (2005)

1/ Numbers in parentheses indicate the year of the first proposal regarding introducing universal health care.
Note: IP denotes inpatient care, and OP denotes outpatient care.