11th CARIBBEAN CONFERENCE ON NATIONAL HEALTH FINANCING INITIATIVES

"BALANCING QUALITY CARE & FINANCIAL SUSTAINBILITY: CASE OF THE QUEEN ELIZABETH HOSPITAL, BARBADOS"

CAPTAIN DON'S HABITAT, BONAIRE

OCTOBER 25 – 27 2016

PRESENTER : DR DEXTER JAMES, CEO

Presentation focus

- How has the increased demand for services particularly strained the resources of the QEH?
- What strategies have been adopted to balance demand for quality care with financial sustainability?
- What new strategies including service changes are being considered to achieve better balance between quality care and financial sustainability?

Our response

- Overview of the Health profile of Barbados
- 15 years of hospital reform – The Good; The Bad; and The Ugly
- The ‘structural challenge’ – health/hospital ecosystem cost drivers
- My reflection – Considerations on sustainability

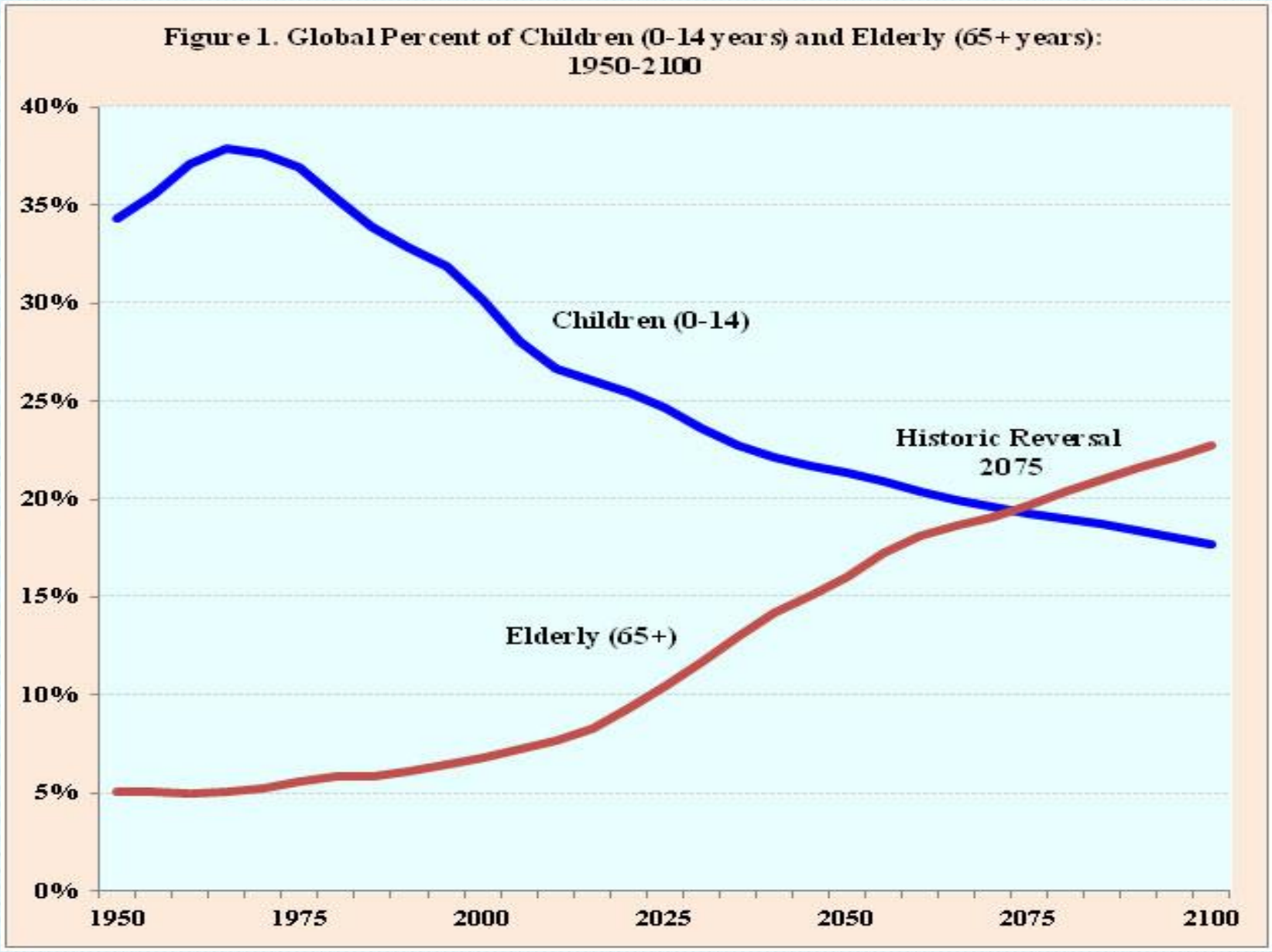
Part 1

OVERVIEW OF HEALTH PROFILE OF BARBADOS

Barbados Health Status

- Leading causes of death : heart disease, diabetes, cerebro-vascular disease, hypertension, prostate cancer
- 8 of10 leading causes of death were from NCDs
- 25% of Barbadians adults have at least one chronic disease
- Projections growth in NCDs: one in three (33%) by 2025
- Barbados has one of the highest proportions of centenarians in the world and 14% of population are over 65 years with rate expected to rise to 18% by 2025

Source: PAHO Health in Americas, Barbados Country Profile, 2012



Source – United Nations Population Division

Table 1. Countries and Cumulative Total by Year of Historic Reversal: 1995-2030.

Year	Number	Total	Country
1995	1	1	Italy
2000	6	7	Bulgaria, Germany, Greece, Japan, Portugal, Spain
2005	8	15	Austria, Belgium, Croatia, Estonia, Hungry, Latvia, Slovenia, Ukraine
2010	5	20	Czech Rep., Finland, Lithuania, Sweden, Switzerland
2015	10	30	Bosnia-Herzegovina, Canada, Croatia, Denmark, France, Malta, Netherlands, Poland, Romania, Serbia
2020	5	35	Cuba, South Korea, Singapore, Slovakia, United Kingdom
2025	7	42	Barbados, Cyprus, Montenegro, Norway, TFYR Macedonia, Thailand, United States
2030	14	56	Albania, Armenia, Australia, Belarus, Chile, China, Georgia, Iceland, Ireland, Luxembourg, Mauritius, Moldova, New Zealand, Russia

Source – United Nations Population Division

Recurring health spending by Sources of financing

Source	Total Health Expenditure '000	%
Government	405.2	55.3%
Households	285.8	39.0%
Employers (via Insurance Scheme)	36.6	5.0%
Donors	2.9	0.4%
NGO	2.2	0.3%
Total	**732.7**	

Barbados 2012-2013, Health Accounts Report, (December 2014)

Key health indicators for Barbados and comparative countries

Indicator	Barbados	St. Vincent	St. Kitts	Dominica	Caribbean Average	Antigua & Barbuda	Bahamas	T&T
THE per capita	1,291	881	856	403	551	681	1,647	972
THE as a %GDP	8.7	5.3	6.0	6.1	6.1	5.2	7.5	5.4
Gov't spending as %THE	55.5	72.0	37.0	62.0	61.0	75.4	46.1	50.4
Gov't health spending as % of Gov't spending	11.1	15.0	8.9	15.5	12.0	17.8	15.7	7.6

Source: Barbados 2012-2013 Health Accounts Report (December, 2014)

Facts on heart attacks

- ≈14 acute MIs/month abstracted from QEH
- Almost 90% of acute MI patients have hypertension
- Almost 80% acute MI patients are also obese
- Almost 75% acute MI patients have diabetes
- In-hospital death rate is estimated at 35%
- Average length of stay (ICU & Wards): 9 days

Source: Barbados National Registry, 2013

Facts on strokes

- ≈53 strokes/month
- About 75% of stroke patients have diabetes
- About 50% of stroke patients are obese
- About 90% of stroke patients also have hypertension
- Almost 33% of stroke patients have a family history of strokes

Source: Barbados National Registry, 2102-2103

Incidence of Cancers in Barbados

Male

1. **Prostate**
2. **Colon**
3. **Trachea, bronchus and lung**
4. **Stomach**
5. **Rectum**

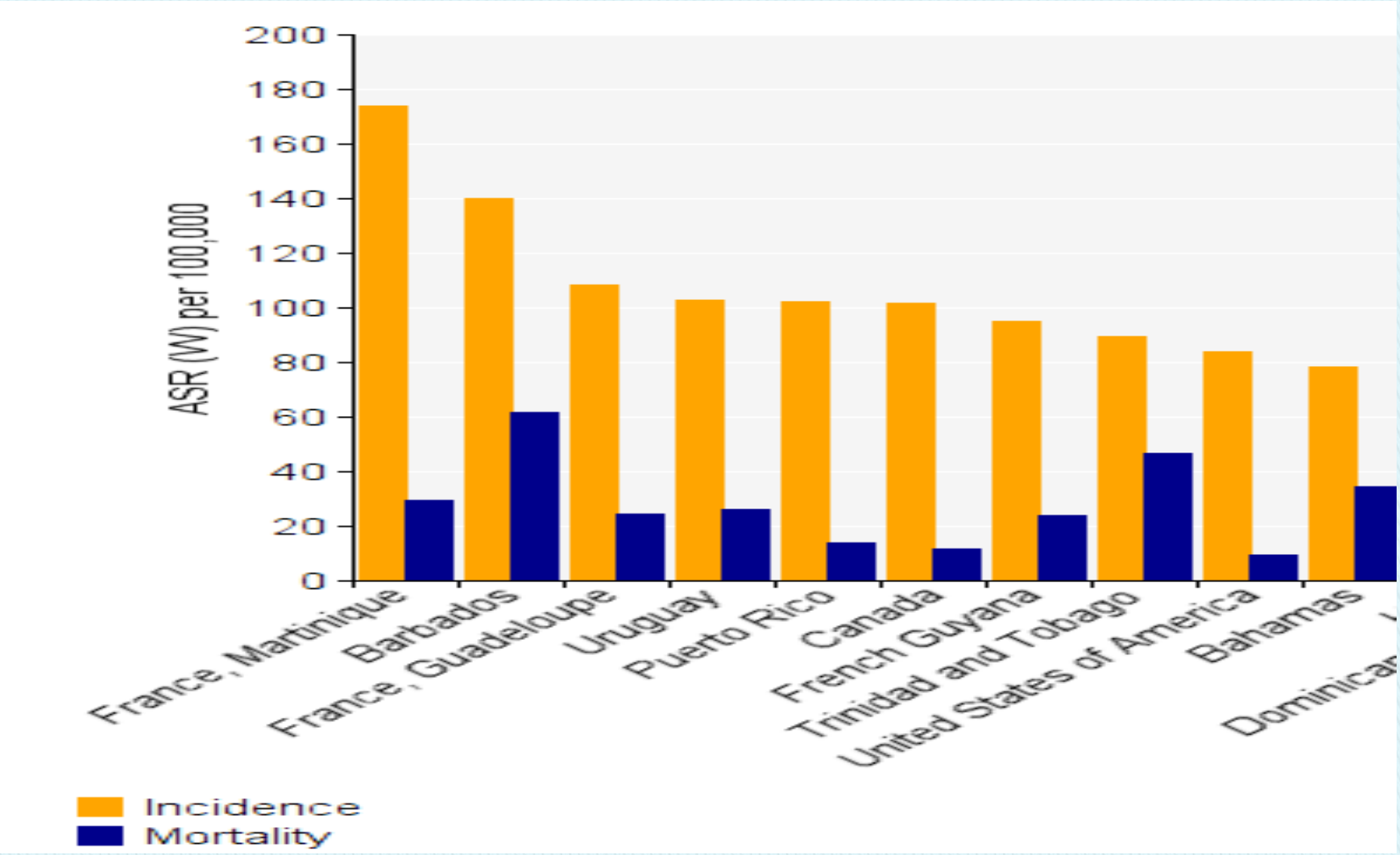
Female

1. **Breast**
2. **Colon**
3. **Cervix uteri**
4. **Corpus uteri**
5. **Rectum**

Source: Barbados National Registry, Volume 3 June 2014

Source: Barbados National Registry, Vol 3, June 2014

PROSTATE CANCER - ***"…though second in the world in incidence for 2008, Barbados is estimated to have the highest mortality rate for Prostate cancers in the world for 2008 (Globocan, Jan 2014)***



Part 2

15 YEARS OF REFORM – THE GOOD, THE BAD & THE UGLY

THE NEW MANDATE FOR CHANGE- DELEGATED AUTHORITY UNDER THE QEH ACT, 2001-14,, SEC (3)(4)(6)

- Provision of care Sec 3(a)
- Facilitate research (Sec 3(b)
- Access to facilities and to services (Sec 4)
- Prudent management & efficient maintenance (Sec 6(1)(b)
- Continuous improvement in quality (Sec 6(1)(d)
- Organizational design (Sec 6(1)(e)
- Provide and maintain equipment (Sec 6(1)(f)
- Disaster preparedness (Sec 6(1) (g)
- HR management, incl. discipline (Sec 6(1)(h)
- Approve new financial codes (Sec 6(1)(j)
- Prescribe and collect fees (Sec 6(1)(l)

HSR evaluation metrics – selected indicators

Criterion	Working definition	Evaluation metrics
Access	The presence or absence of physical or economic barriers that people might face in accessing health services (Knowles et al 1997)	▪ Proximity to services ▪Healthcare utilization ▪Availability of emergency transport ▪Doctor population ratio
Equity	Differences/disparities in health status, utilization or access among different income, socioeconomic, demographic, ethnic and/or gender groups (Knowles et al 1997).	▪Health Expenditure
Effectiveness & Efficiency	Considers outputs and cost dimensions	▪Throughput ▪Unit cost analyses ▪Demographic indicators
Quality	This is multidimensional concept on which there is little consensus; however, outcome; quality in addition to health status can include patient satisfaction and perceived quality. (Knowles et al 1997)	▪Patient satisfaction and perceived quality ▪Levels of incidents and complaints ▪Falls and ulcers
Sustainability	Are we generating enough revenue to pay for the health care services we are providing?	▪Revenue & expenditure analyses ▪Solvency ▪Collections performance

Bed distribution

Service	# of Beds
Medicine	96
Surgery	96
Paediatrics	51
Obstetrics	58
Gynaecology	33
Orthopaedic	32
Ophthalmology	31
Radiotherapy	23
Psychiatry	8
Babies	32
ENT	16
ICU's (MICU & SICU)	12
NICU & PICU	53
Private	43
Total	584

Clinical Infrastructure

- Accredited teaching facility by U.W.I
- Comprehensive package of medical, surgical and rehabilitative services. Visit: www.qehconnect.com
- ICU's (neonatal and paediatric)
- Diagnostic imaging – x-ray, CT, mammography, ultrasound, special studies
- 6 ORS and 2 obstetric theatres
- Specialist services:

  - ✓Radiotherapy & chemotherapy
  - ✓Invasive Cardiology
  - ✓Neurosurgery & neurology
  - ✓ENT
  - ✓Renal therapy (haemodialysis, peritoneal dialysis and kidney transplants)

In and Out-patient activity

Services	Annual Patient Throughput
Admissions	16,500
Out-patient Services	90,000
Average length of stay	6.4 days
Bed Occupancy	70%
Surgeries done	5,900
Deliveries	2,600

Source: QEH Medical Records Department

Emergency services

Services	Annual Activity levels
Accident & Emergency	40,000 visits
Emergency Ambulance Services	13,000 call responses

Source: Accident & Emergency & EAS departments

Canadian Triage Acuity Scale (CTAS)- Barbados Modification

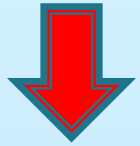
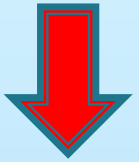
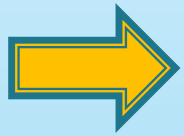
Category	Description	Comment(s)	FIGURES IN 2014
1	Patients with life-threatening conditions	Priority patients requiring emergency intervention (Airway, Breathing, Circulation problems)	3.0%
2	Patients with urgent, but non life-threatening conditions	These patients require urgent care and treatment. May often require hospitalization. They are a cause for concern as they can become category 1 if not seen in a timely manner	20.3%
3	Patients with non-urgent conditions but require treatment at the hospital	Require diagnostics/services not provided at other public facilities	44.4%
4	Patients with non-urgent conditions who can be seen elsewhere	Not considered high priority and therefore can wait for extended periods for service	25.1%
5	Patients seen previously and have scheduled reviews	Not necessarily high priority but require follow up	7.0%

Expanded Access – Medical Aid Scheme

Years	Applications processed	Applications Approved	Committed Funds ('000)
2007	137	96	2,091
2008	139	85	3,898
2009	140	92	4,806
2010	52	29	890
2011	60	29	1,404
2012	35	40	2,128
2013	31	29	1,851
2014	57	25	1,018
2015	44	24	138

Source: Social Services department

Operating room utilization

	Standard	2012	2013	2014	2015	Trending
Surgeries Booked		6857	6388	5864	5859	
Surgeries Done		5356	4936	4637	4591	
Utilization factor	95%	78%	78%	79%	78%	
Public	75%	4151 (78%)	3815 (77%)	3710 (80%)	3646 (79%)	
Private	25%	1205 (22%)	1121 (23%)	927 (20%)	945 (21%)	

Source: Operating Theatre

Physician Ratios per 100,000 Population

	International[1] Standard	Barbados[2]
Cardiology	4.2	8
Nephrology	0.7	1[3]
Internal Medicine	19.0	27
General Surgery	6.0	16
Cardio Thoracic	1.4	2
Neurosurgery	1.5	2
Ob/Gynaecology	10.2	18
Ophthalmology	4.7	22
Orthopaedics	6.1	10
Urology	2.9	4
Anesthesiology	13.5	16
Radiology	9.5	13
Paediatrics	15.7	20
Emergency	12.3	13

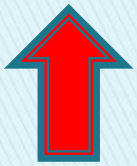
[1]Solucent (2003). Physician to Population Ratios
[2]Barbados Medical Council (2015)
[3] Identified as Internal Medicine on Specialist Register

Diagnostic & Therapeutic activity

Services	Annual Activity levels
Prescriptions filled	>350,000
Laboratory investigations	>3,700,000
Diagnostic Imaging studies	>42,000
Rehabilitation Services	> 7,500
Meals prepared	26,000 per month

Source: Heads of Departments

Incidents and Complaints (2011-2015)

Sources	2011	2012	2013	2014	2015	Trending
Incidents	2233	2259	1820	1358	1337	
Complaints	41	179	127	100	144	

Source: Clinical Risk department

Patient happiness factor (by dimension of care)

Area of satisfaction	Average satisfaction score (out of 5)	Rank
Quality of Medical Care	4.3	1st
Quality of Nursing Care	4.23	2nd
Quality of physical environment	4.16	3rd
Quality of Meal Services	3.7	4th

Source: Dwayne Devonish (2015). Patients' Satisfaction with care at the QEH

Net Promoter Score – 2015

Type of patient	Percent in Sample
Promoters	36%
Passives	50%
Detractors	14%

QEH's Net Prompter Score (22) < Hospitals and Healthcare institutions globally (65)

Source: Dwayne Devonish (2015). Patients' Satisfaction with care at the QEH

Launch of A.I.M High for Excellence & Quality Initiative

- A.I.M – '*Achieving Improved Measurement*'

- 5-areas of service quality enhancement:
  - Laboratory accreditation (ISO 15189)
  - Baby-Friendly Hospital Initiative (BFHI) recertification under WHO/UNICEF
  - HACCP certification for improving food safety
  - International Code of Practice for Information Security Management (ISO 27001)
  - Hospital-wide accreditation

Innovation and Technology

Technology	Quality Improvement
Tele-radiology (PACS)	•Real time access to reading and reporting on images •Cost savings – redundancy in dark room operations & printing
Laparoscopic surgery	•Reduction in length of stay •Reduce costs
Datix application (clinical risk management	•Patient safety •Reporting of complaints, accidents, incidents and adverse events •Risk management
Abacus application	•Patient dispensing
Peachtree application	•Patient accounting and billings
Infor/EAM	•Preventive maintenance •Asset Priority dispatch system
Laboratory Information system	Real time access to results (selected areas)
Equipment prospectus	▪Acquisition of new equipment ▪Replacement of obsolete equipment

Revenue analysis (2011- 2015)

Sources	2011	2012	2013	2014	2015
Patient Revenue	5,436	4,769	6,486	6,778	7,659
Other revenues	116	46	385	610	324
Total revenues	**5,552**	**4,815**	**6,871**	**7,388**	**7,983**

Source: Finance Department

Revision to deposit policy

- Revision to policy in November 2011
- Escrow deposit in advance (elective surgery)
- Deposit based on Hospital Fees Regulations (2006):
  - Estimated length of stay (ALOS)
  - Operating room
  - Hospitalization
  - Consumables utilized
- Collection performance rate: 80%
- Admissions by country:

Country	2011	2012	2013	2014	2015
St. Lucia	6	13	18	25	12
St. Vincent	4	14	23	18	18
Dominica	6	14	26	29	18
Antigua	1	8	6	6	9
Anguilla	2	6	4	2	4
Grenada	1	5	8	4	5
Others	8	32	51	63	54
Total	**28**	**92**	**136**	**147**	**120**

Donations to Charities

- The QEH is defined as an **Exempt Charity** within the meaning of the Income Tax Act

- Where a settlement is made to a registered charity or an exempt charity in income year 2009 or subsequent income years, in calculating the assessable income of the person making the settlement, there shall be deducted from income of that person in accordance with subsection (2) and (3) (Sec 24 (1)

Donations Received – Stratified by Beneficiaries

Entity	Value of Donations
Surgical Intensive Care	424,500.00
Medical Intensive Care	1,600,000.00
Ward C9	550,000.00
Oncology/ Nuclear Medicine	4,791,850.00
Gynaecology / Diagnostic Clinic	81,696.00
Cardiovascular Services	2,000,000.00
Others	142,390.00
Cash	691,858.00
Total	**$ 10,282,294.00**

Source: QEH Donations Regi

Part 3

THE ‘STRUCTURAL’ CHALLENGE – HEALTH/HOSPITAL ECOSYSTEM COST DRIVERS

Approved budget analysis (2012-2016)

Programme	2012 ('M)	2013 ('M)	2014 ('M)	2015 ('M)	2016 ('M)
Direction and Policy Formulation	27.8	29.9	19.9	25.0	26.1
PHC	27.3	31.0	29.7	27.2	28.3
Hospital Services	**164.2**	**198.6**	**187.4**	**168.6**	**160.4**
QEH	155.7	190.0	178.0	163.1	155.4
EAS	4.0	4.1	4.9	3.3	3.3
MAS	3.5	3.5	3.5	1.8	1.8
Redevelopment	1.0	1.0	1.0	0.4	0
Psychiatric Hospital	30.9	31.1	32.2	32.1	30.0
Care of Disabled	2.8	2.8	2.8	2.6	2.8
Pharmaceutical Programme	29.6	31.7	29.6	27.7	26.2
Care of the Elderly	38.4	40.1	39.6	33.3	36.1
HIV/AIDS Prevention & Control	9.3	16.5	13.6	11.2	10.2
Environmental Health Services	17.5	20.2	18.9	14.5	16.0
TOTAL	**347.8**	**401.9**	**373.7**	**342.2**	**336.1**
QEH's Share	**47%**	**49%**	**50%**	**49%**	**48%**

Source: Approved Budget Estimates

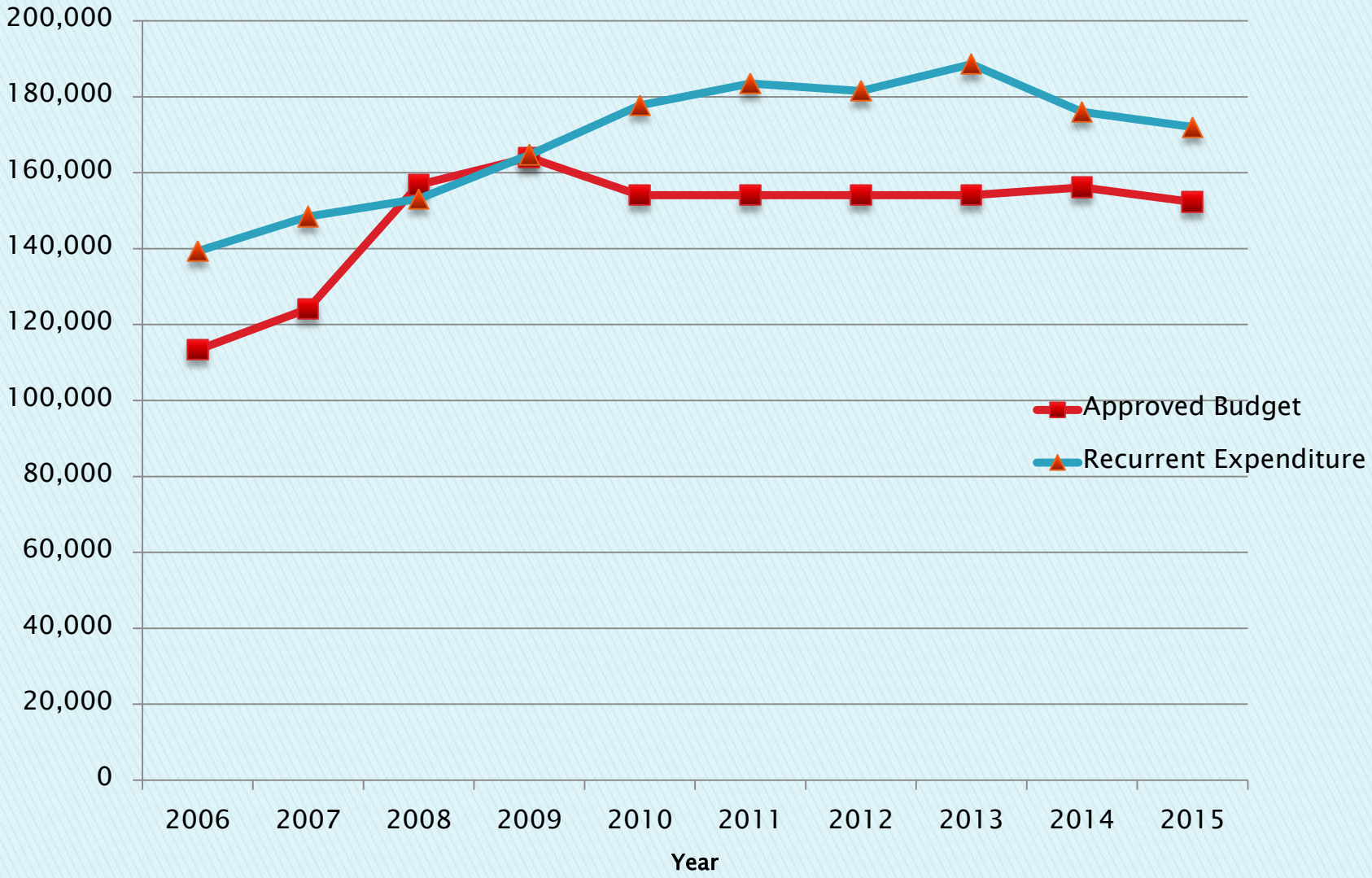
Budget vs Expenditure Review

Year	Approved Budget ('000)	Recurrent Expenditure ('000)	Finance Gap ('000)
2006	113,369	139,345	-25,976
2007	124,152	148,486	-24,334
2008	156,849	153,130	-3,719
2009	164,024	164,743	-719
2010	154,094	177,772	-23,678
2011	154,094	183,535[1]	-29,441
2012	154,094	181,545[2]	-27,451
2013	154,094	188,591[3]	-34,497
2014	156,132	176,053[4]	-19,921
2015	152,276	172,051	-19,775

Source: Estimates of Revenue and Expenditure; Finance Department

[1-4]Unaudited balances

Budget vs Actual Expenditure



Haemo-dialysis services - update

- From 3 patients in 1979 to 275 in 2016
- 184 patients managed by AKU
- 55 patients on home dialysis
- 36 patients outsourced to private provider
- 4-5 new patients initiated on haemo-dialysis per month
- 2-3 new patients on peritoneal dialysis per month

Source: Artificial Kidney Unit

Cost of renal services

	# of patients	Annual Cost per patient treatment ($)	Total Cost ($)
Haemodialysis	184	62,400	11,481,600
Outsourcing	36	46,800	1,684,800
Peritoneal (Home Dialysis)	55	50,000	2,750,000
Total			**15,916,400**

Facts on in-patient diabetes

- Prevalence of inpatient diabetes (42.5%) or 111 of 261 beds– highest documented in English medical literature
- Of diabetes related admissions, 89% were for active diabetic foot diseases
- Median length of stay : 19 days
- 30% of all recoded reasons for admissions of patients with diabetes were due to diabetic foot disease

Source: Taylor, C et al, 2014. Clinical Medicine 2014 Vol 14, No.4 367-70

Budget, Supplementary and AR's – GoB

Year	Approved Budget ('000)	Supplementary funding ('000)	Accounts Receivable – GoB as at March 31 ('000)
2006	113,369	3,526	0
2007	124,152	20,059	0
2008	156,849	18,471	0
2009	164,024	18,914	0
2010	154,094	4,294	0
2011	154,094	0	5,678
2012	154,094	10,200	8,374
2013	154,094	44,500	63,394
2014	156,132	32,000	57,009
2015	152,276	18,000	68,648

Source: Estimates of Revenue and Expenditure; Finance Department

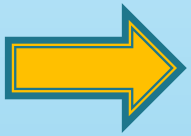
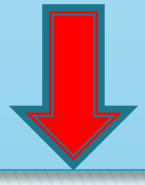
[1-4]Unaudited balances

Liquidity analysis

Sources	2013 (‘000)	2014 (‘000)	2015 (‘000)
Quick Assets			
Cash & bank Balances	7,105	5,031	4,940
AR-Trade	6,984	4,855	5,089
AR-GoB	63,394	57,009	68,647
Total Quick Assets	**74,483**	**66,895**	**78,676**
Current liabilities			
Overdraft	6,751	6,169	6,793
Trade payables	23,409	34,650	45,206
Other payables	54,726	34,105	46,573
Total current liabilities	84,886	74,924	98,572
Working capital	**(10,403)**	**(8,029)**	**(19,886)**

Source: Finance Department Unaudited balances

HSR evaluation metrics – summary findings

Criterion	Evaluation metrics	Trending
Access	▪ Proximity to services ▪Healthcare utilization ▪Availability of emergency transport	
Equity	▪Health Expenditure	
Effectiveness & Efficiency	▪Throughput ▪Unit cost analyses ▪Demographic indicators	
Quality	▪Patient satisfaction and perceived quality ▪Levels of incidents and complaints	
Sustainability	▪Revenue & expenditure analyses ▪Solvency ▪Collections performance	

Strategy & outcomes mapping

Strategy	Outcome
Exploit ICT & Telemedicine solutions	▪Improved real time access for diagnostics, second opinions and reduced operating costs
New deposit policy for elective care	▪Minimization of patient receivables ▪Improvement to cash flows
Implement clinical risk management	▪Mitigate risks of adverse events
A.I.M initiatives	▪Reduce liability costs ▪Improve quality and safety
Outsourcing of selected services	▪Mobilize access to idle health system resources ▪Economies of scale
Expansion of revenue base through philanthropy	▪Generation of capital funding for replacement of obsolete equipment
Strengthen materials management processes	Lower costs: ▪Use of generics (F) lower costs ▪Tendering for food and medical supplies
Anti-microbial stewardship programme	▪Rational prescribing patterns ▪Improved surveillance of infectious

Part 4

MY REFLECTION

THE ‘5’ IN ‘50’ CONSIDERATIONS –

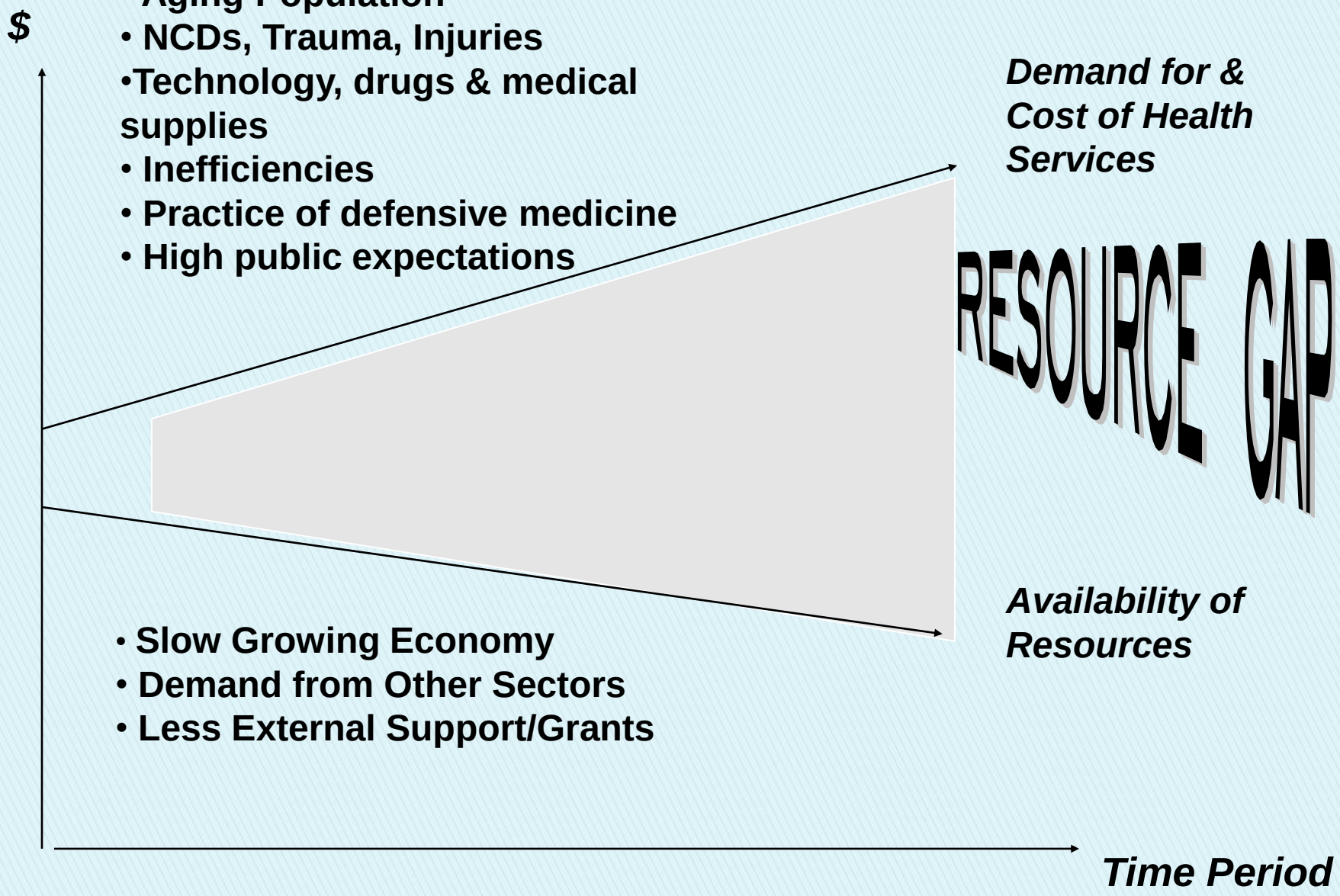
THE NEW FRONTIER & VISION FOR THE FUTURE

Common concerns across the globe

- Increasing health care cost
- Protect people from financial consequences of health care payment
- Expand fiscal space in spite of macro-economic constraints
- Use of available resources efficiently and equitably

For all these, Health care financing is moving towards Universal Health Coverage (UHC)

Health / Hospital Financing Dilemma



Collision of supply and demand drives up healthcare costs

New, more expensive therapies and diagnostic investigative tools

Major information projects

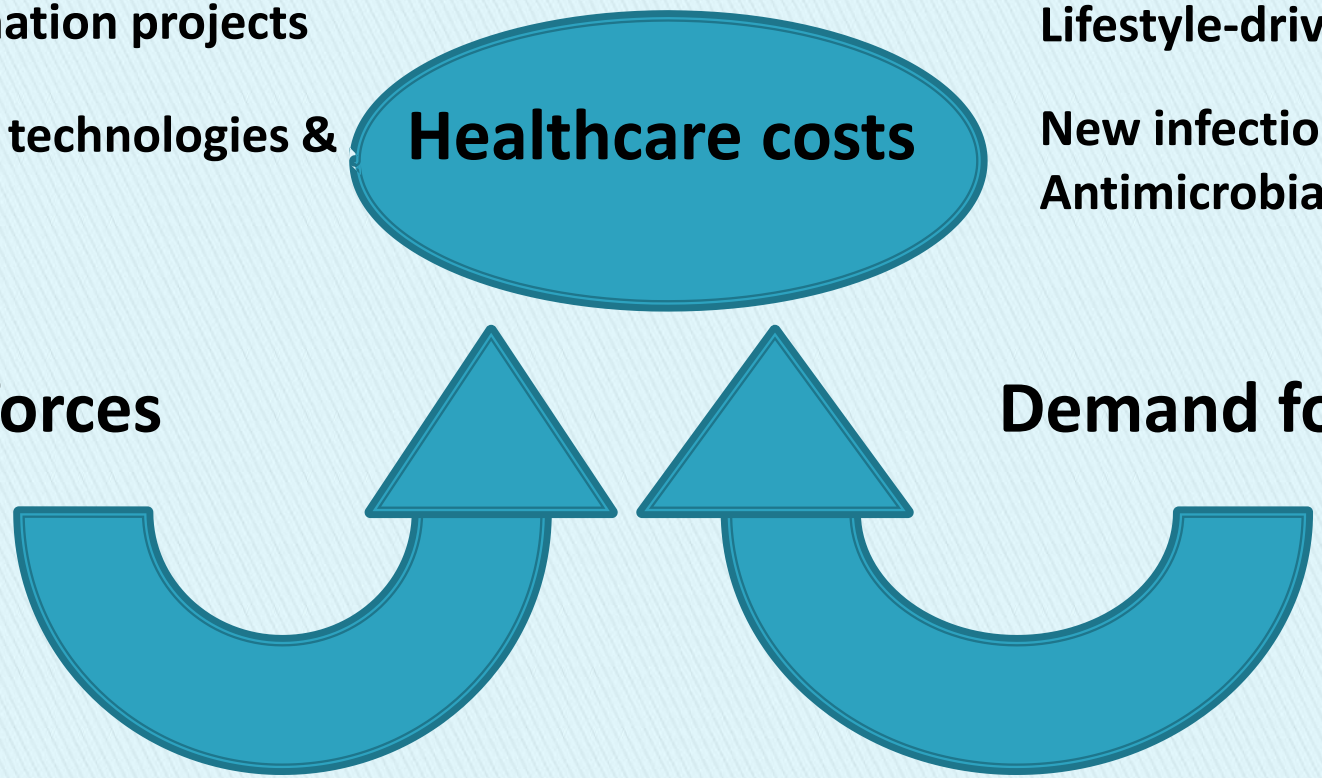
New medical technologies & disciplines

Higher expectations

Aging populations

Lifestyle-driven disease

New infectious diseases
Antimicrobial resistance



2010 2030 2030 2010

THE POLICY OPTIONS

- **OPTION 1** - DO NOTHING!!!

- **OPTION 2** - RESPOND TO THE IMPERATIVE OF URGENT CHANGE – THE NEW FRONTIER

Considerations around sustainability

Critical Success Factors	Strategy
1. Re-engineering of health and health care systems	• Conduct Efficiency Audit of public health system - eliminate / minimize systemic inefficiencies such as: ▪ Inappropriate admissions to A&E department and lengths of stay ▪ Adverse incidents, medical errors ▪ Overuse, misuse or underuse of particular interventions (relocate demand and cost) ▪ Actuarial study to ascertain levels of funding to sustain financing of the essential package of services ▪ Move towards a digital hospital – leverage the benefit of ICT. Expand telemedicine technology: ▪Tele-triage ▪Tele-pathology & ophthalmology ▪ e-prescribing ▪e-citizenship

Considerations around sustainability

Critical Success Factors	Strategy

1. Re-engineering of health and health care systems (Con't)	▪ Implement Electronic Medical Records (EMRs) for evidence-based approaches
	▪ Building alliances with strategic partners
	▪ Explore the option of Full Time Equivalent (FTE) for selected categories of staff e.g. nursing, radiologists
	▪ Continuous improvement and innovation
	▪ Clinical services re-design:
	  ▪ The need for more critical care beds (retraining of staff)
	  ▪ Billings (full cost) to every patient, insured, subsidized or free
	  ▪ Review admission & discharge processes
	  ▪ Developing clinical protocols
	  ▪ Centralize waiting lists

Considerations around sustainability

Critical Success Factors	Strategy
2.Improvement to fiscal management and funding model that drive desired behavioral change	▪More money is not necessarily the answer for sustainability but rather greater alignment of funding, quality and accountability frameworks ▪Shift away from global funding model towards a wider use of activity-based funding models (pay for performance) that compensate for patients treated, services provided and outcomes ▪Activity-based models should be applied to physician compensation which is major component of total health care costs: •Hospital is seen as a 'free' workshop •All patients seen are private ▪Levels of compensation (charge out) based on reasonable and customary charges ▪Savings: No terminal pay

Considerations around sustainability

Critical Success Factors	Strategy

2. Upgrade fiscal management and funding model that drive desired behavioral change (con't)	▪ Introduce Service Level Agreements (SLAs) as a basis for promoting internal efficiency within and among healthcare deliver system (transfer pricing)
	
	▪ Diversification of revenue base –
	  ▪ Exploit hospital philanthropy
	  ▪ Commercialization of spare capacity in diagnostic services
	  ▪ Leverage spare OR capacity – offer Admitting Privileges for private use
	  ▪ Drop-off service for filling of prescriptions

Considerations around sustainability

Critical Success Factors	Strategy
2. Upgrade fiscal management and funding model that drive desired behavioral change (con't)	▪ The need for ethical discussions around breadth of population coverage, scope of benefits provided and /or depth of services publicly financed ▪ Change in legislation/regulations to permit charge-out of services to insured persons ▪ Costing studies to determine the full economic cost of services. In the interim while waiting for full NHI, charge -out services to: ▪ Private insured ▪ Private insurance to accident victims treated ▪ Non-resident patients e.g. tourists, CARICOM patients ▪ Private use of OT

Considerations around sustainability

Critical Success Factors	Strategy
3. Effective disease prevention and health promotion	▪ Primary health care reform initiatives: - rethink the package. e.g. delivery of primary medical care, oral health ▪ Reforms must embrace private sector (SwAP) participation as a provider ▪ Strengthen monitoring and evaluation frameworks for health indicators - review of programmes with emphasis on impact and outcomes as opposed to outputs ▪ Introduction of pay-for-performance to motivate physicians to reach higher immunization and screening targets e.g. Healthy Communities initiative by PAHO ▪ Introduce health promotion and prevention strategies in the workplace (employee wellness)

Considerations around sustainability

Critical Success Factors	Strategy
4. Revisit governance model – the metamorphosis	▪ From Board of Management to a non-political Board of Governance funded by Gov't via a negotiated 2-3 year SLA ▪ Review expansion of the scope of legislative authority of the QEH to integrate PHC services. Benefits include: ▪Integrated and coordinated care ▪Sharing of resources ▪Cost-economies through procurement ▪ Greater autonomy to manage people resources – separate from the central Ministries of Health and Civil Service

Considerations around sustainability

Critical Success Factors	Strategy

5. Creating stakeholder value – patients are the solution…not the problem	▪ Dedicated arrangements for reducing waiting lists across clinical and diagnostic areas
	▪ Improvement to response times (A&E, diagnostic investigations, OP appointments, medical reports)
	▪ Improve supplier relationships
	▪ Customer service orientation:
	  ▪ Drop-off service for filling of prescriptions
	  ▪ Use of third party collections for billings
	▪ Improvement to service quality, patient safety and costs– the pursuit of Hospital-wide Accreditation (A.I.M initiative)

Policy questions on sustainability

- Increasing health care costs (demand for resources) are a serious threat to health and health care sustainability

Policy questions:

- How is the health system to be financed and sustained, given changes in population demography and health profile?
- How does spending growth matches up with economic growth?
- Are we generating enough revenue to pay for the health care services we are providing?
- Does our existing health care policy focus on sustaining the health systems performance within the current and future financial constraints?
- What are the required changes that encourages the optimum use of available resources?

The health financing policy option

"*If the Total Health Expenditure (THE) of $743.3M or 8.7% of GDP currently expended on healthcare is mobilized and collected, pooled, allocated and utilized to compensate providers under a new construct such as NHI (et al), will these funds be adequate to sustain the current package of services provided to the people of Barbados*"

"…preserving **access** to key social services provided at the highest **quality** and financed in a **sustainable** and credible manner".

Source: Exert from Budget Speech by Minister of Finance, August 16 2016