MINISTRY OF HEALTH & WELLNESS

VISION FOR HEALTH 2030

TEN YEAR STRATEGIC PLAN 2019-2030

TABLED FOR DISCUSSION

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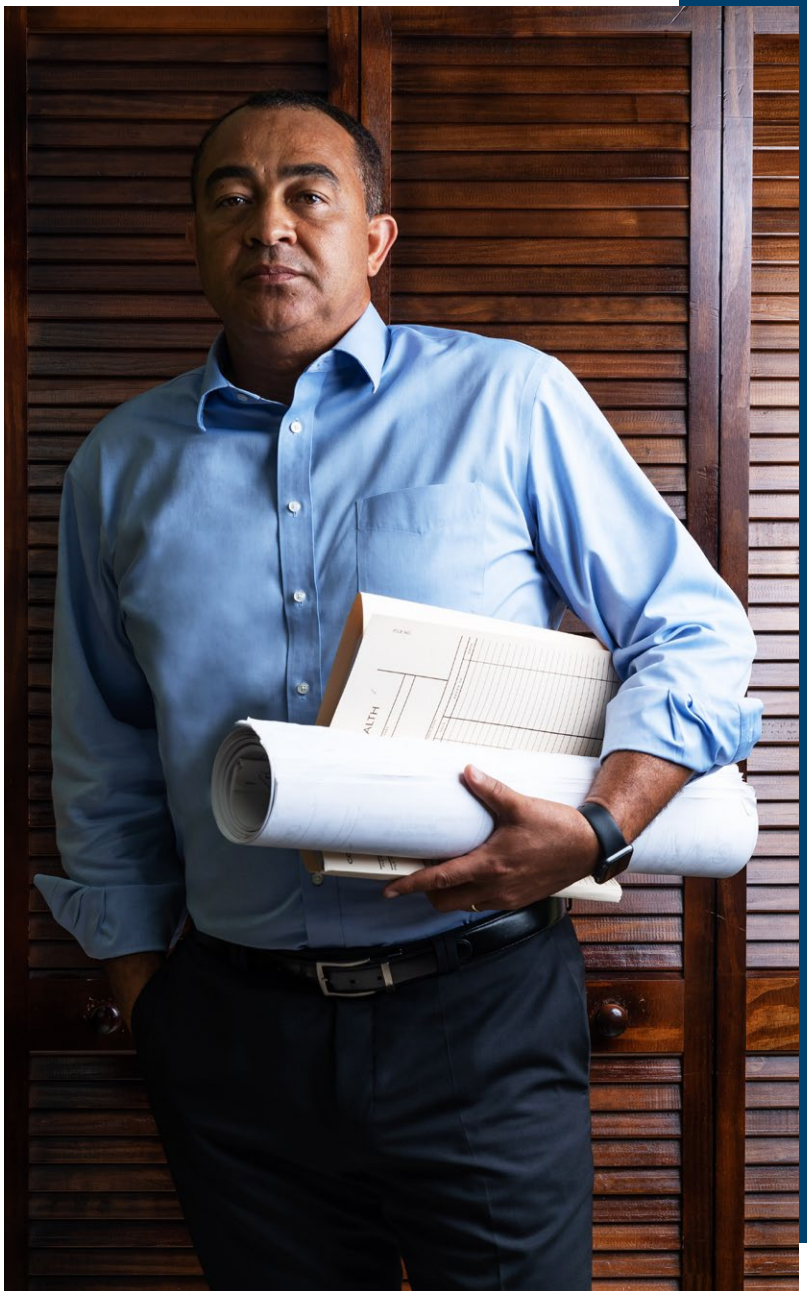
FOREWORD



This Vision for Health 2030 - Ten-year Strategic Plan signals our intentions and communicates our vision for the health of and health care delivery system for our population. For the next ten years, our challenge is to find the most effective mix of prevention and treatment measures that makes the best use of our resources in improving health and extending life. With the compassionate care programme and ensuring that hospitals, specialized care centres and support services are modernized to provide efficient and quality services in an aesthetically pleasing environment – we are striving to give patients the best experience when utilising public sector healthcare services.

A combination of studies conducted and first-hand experience has revealed gaps in leadership and governance. Despite agreement on the urgent need for reform, this did not translate into clear policy direction and guidelines in order for the Government to make timely and appreciable steps. This Strategic Plan provides that structure and clarity.

The Vision for Health 2030 - Ten Year Strategic Plan lays out the basis for gaining consensus around the health financing initiatives that will enable the Government to finance these reform programmes. Universal Health Coverage and Universal Access to Health remains a priority and the tangible commitments in this Strategic Plan are to ensure that the population is able to access i) quality care at upgraded facilities, by trained staff with the appropriate mix of skills, ii) required levels of equipment, pharmaceuticals, and supplies, and iii) the requisite financial protection.

Attaining optimal health is now well beyond the walls of the health facilities and health outcomes can only be improved by addressing social determinants of health and by promoting personal responsibility. This challenges the traditional view of the health sector domain and only through leadership and advocacy can the goal of enhanced health and welfare be attained.

As a Nation, we have bold decisions and choices to make to respond to the current health needs and safeguard our future generations; we need a new paradigm to transform health and health care delivery.

Dr. the Hon. Christopher Tufton, MP
Minister of Health & Wellness

EXECUTIVE SUMMARY OF THE STRATEGIC PLAN

The Vision for Health 2030 - Ten-Year Strategic Plan ("Vision for Health 2030 Plan") was developed in response to a comprehensive situational analysis, whereby the gaps of the health system were identified, while simultaneously analyzing the direction the system should take based on consultations with stakeholders, practical evidence from applicable countries, and most importantly, the development and enhancement of resources that Jamaica already possesses.

The Vision for Health 2030 - Ten-Year Strategic Plan consists of strategic lines organized under four main components: The Standard Comprehensive Essential Benefits Package (SCEBP), the Health Service Delivery Network, Finance and Governance. Vision for Health 2030 Plan further consists of two supportive components: Human Resources and Infrastructure.

The Ministry of Health & Wellness has developed a Standard Comprehensive Essential Benefits Package based on the country's epidemiological profile and which includes benefits that will be the most impactful on Jamaica's health, as well as cost-effective. The SCEBP is to be implemented vis-à-vis the life-cycle approach in order to ensure a patient-centered approach. The SCEBP is aimed at attaining universal health coverage (UHC) and universal access to health (UAH) for the country[1].

In order to effectively provide the SCEBP, it is necessary to re-structure the health service delivery network, which will provide the complimentary structure towards alignment goals of the Vision for Health 2030 Plan. The purpose of the re-structuring of the network is to strengthen the first level of care (FLC) and essentially revive primary care, which is known to not only be cost-effective but to be easily attainable and properly address the population holistically, which is increasingly important with the high prevalence of non-communicable diseases (NCDs).

To attract patients towards utilizing primary care, the Vision for Health 2030 Plan has identified the need to restructure the categories of health centres and reduce them from five to three categories/ types: Community, District and Comprehensive. This move ensures that existing structures and outdated disease profiles do not consume required resources, but rather, that the health centres provide services that are in demand by patients today, and possess the staff and equipment in a welcoming infrastructure to improve the quality of care.

In addition, the Vision for Health 2030 Plan calls for increased cooperation and seamless transition between the levels of care. The ease of moving between levels is supported by a health information system (HIS) that allows patient's information to be shared by doctors at each level, which cuts down on time and repetition of diagnostics, analysis and services. Moreover, the incorporation of a rural outreach network provides necessary follow-up care, critical for the elderly and those with mobility challenges, and allows for screening, basic care, and preventative measures to take place in patients' homes and within the community. The goal of the re-designed system is to provide quality, accessible care to all Jamaicans, and to provide treatment when it is required in its earliest stage, in order to prevent the onset of disease and complications. Those in need of emergency care; specialty care and surgery will find a less congested hospital that is better equipped, resource wise, to handle patient flows.

The Vision for Health 2030 Plan outlines the financing required for the public health sector in accordance with established international benchmarks. In the short and medium-term, it is recommended to consolidate the existing finance base to ensure implementation of a health benefit package/National Health Insurance (NHI) scheme, through:

- **The gradual increase in direct government funding toward the PAHO benchmark on 6% of GDP as public investment in health;**
- **The establishment of a health care reserve (The Health Fund) under the MOHW for particular discretionary investments related to the Vision for Health 2030 Plan implementation.**

The long-term recommendation is the development of the basis for establishing two strategic finance sources to complement the existing government finance sources:

- **The establishment of a National Health Insurance (NHI) scheme;**
- **The implementation of a series of policy measures to promote efficiency gains and spending rationalization in the health care sector.**

The gradual increase in direct government funding was calculated and necessitates 6% of GDP, which would create the base of the fiscal space for health. It is acknowledged that this increase in direct government spending may not be allocated entirely to the strategic objectives but rather for business as usual activities; therefore, a Health Care Reform Fund (HCRF) is advised, in order to provide a complementary financial source and ensure the discretionary fiscal space for health care reform initiatives, in particular.

Related to strategic reform priorities, the Health Care Reform Fund (HCRF) will provide the financial basis for implementation of the health benefit package and introduction of a NHI scheme.

[1] Pan American Health Organization. Strategy for Universal Health Coverage of Region of the Americas. Background paper: Framework for the Development of the Regional Strategy. PAHO: Washington DC. 2014.

Further, the introduction of a National Health Insurance (NHI) scheme will guarantee universal coverage, as although Jamaica removed user fees, patients still report not seeking care due to costs. Efficiency gains in the areas of procurement, administration and health institutions have been included. Lastly, the design and implementation of a capitation[2] based finance model has been proposed.

In terms of governance, a number of measures have been suggested. In order to increase efficiency, resource sharing, improved rationalization and accountability, the Vision for Health 2030 Plan proposes the rationalization of the Regional Health Authorities (RHAs). In so doing, opportunities to eliminate duplication of administrative and clerical functions with increased productivity should be encouraged. A restructuring of the RHAs will also result in the implementation of robust Service Level Agreements (SLAs) that are performance driven and developed from the bottom up to better reflect the communities in which they serve.

The restructuring of the Ministry of Health & Wellness (MOHW) is simultaneously suggested, to inter alia, emphasize a technical stream to focus on quality of care, to establish a monitoring and evaluation division to report on the performance of the health facilities; as well as an Internal Audit Unit to examine and report on efficacy and efficiency of the administrative and management processes in each organization within the public health sector. On another note, the Vision for Health 2030 Plan proposes the centralization of procurement with each RHA having a Regional Procurement Office (RPO) and Regional Procurement Committee (RPC) to avoid bottlenecks and improve efficiency. The MOHW should also allocate resources on human resources in procurement, developing a standardization of equipment and committing to a maintenance plan to prolong the useful life of equipment.

In regards to human resources for health, the main objectives can be summarized as:

- **To ensure the availability and quality of highly trained health staff especially for PHC services;**
- **To promote a positive labor environment that motivates employees to work efficiently;**
- **To reduce clinical staff migration by implementing retention policies in the MOHW;**
- **To improve the sustained availability of professional and technical staff throughout the public health sector;**
- **To strengthen the capacity of the Human Resource Management Unit of the MOHW to plan, manage, monitoring and evaluate staffing needs and performance;**
- **To promote the emergence of new working categories that facilitates patient safety and improved relations with the clinical staff;**
- **To identify training needs that speed-up the acquisition of relevant knowledge to implement and operate the new PHC-based model and that provide, at the same time, improved career opportunities for workers**

The challenges encountered by MOHW with regard to human resources for health are migration, a lack of health professionals, and an unequal distribution of health workers (rural vs. urban). Policy recommendations were developed in the areas of: in the short term to deepen existing bilateral arrangements for inward migration to meet human resource needs while in the long run to improve remunerations and career development, human resource management and training. The policies recommended aim to utilize existing resources by re-training professionals to better meet the need of today's disease burden; to attract recently graduated health care workers to the public sector; and to provide a comfortable, pleasant working environment to ensure health professionals remain within the public sector.

The infrastructure and equipment recommendations emphasize the re-categorization of health centers and restructuring them into their new classification, inclusive of services provided and population served. It is further suggested that a mapping of current infrastructure and equipment is carried out, that Public-Private Partnerships (PPPs) are considered, particularly in the medium to long-term to provide needed facility space, personnel or equipment; and that the MOHW looks towards efficiency gains among hospitals.

[2] Capitation involves healthcare providers being paid a fixed amount of money on the basis of number of patients for delivering a range of services

INTRODUCTION

The Ministry of Health & Wellness is responsible for the health of the people of Jamaica and is focused on developing and implementing national strategies for improving health, delivering effective quality health services, setting standards and regulations and carrying out essential public health functions while promoting inter-sectoral actions for health. Acknowledging that a healthy and stable population is needed to drive the country's development, the Ministry of Health & Wellness has developed its Vision for Health 2030 – ten-year Strategic Plan.

This Strategic Plan sets out the goals and health outcomes that the Ministry of Health & Wellness, working with other Ministries and stakeholders and the population at large, is committed to achieve by 2030. It responds directly to the Vision 2030 Jamaica - National Development Plan (Vision 2030)[3] , and it is fully aligned to the long-term vision and outlook for health expressed in its goals and principles. It considers the MOHW's commitment through various initiatives previously undertaken that are outlined in the organization's Strategic Business Plan[4].

Vision for Health 2030 Plan further takes into account the country's international commitments to the Sustainable Development Goals(SDGs) adopted by the member states of the United Nations in September 2015 that provide the framework of our global commitment and contribution to improving the health of the world by 2030[5]. In addition to the SDGs, the Ministers of Health of the Americas approved a strategic policy instrument - The Sustainable Health Agenda for the Americas (SHAA2030), that provides direction and political vision for health development in the Region for the next 13 years[6]. The goals and outcomes of this Strategic Plan are aligned with the SHAA2030 as part of our regional commitments.

Vision for Health 2030 Plan was developed using a consultative approach involving key stakeholders in health and other sectors. It is based on Jamaica's current health situation, emerging health trends, national and global priorities.

Vision for Health 2030 Plan provides a description of key strategic goals and outcomes to be sought and takes into consideration resource implications and financing strategy, and the organizational frameworks required to implement the same. Vision for Health 2030 Plan will support efforts to increase accountability, transparency and effectiveness in the work done by the MOHW.

[3] Planning Institute of Jamaica. Vision 2030 Jamaica - National Development Plan [Internet]. 2012. Available from: http://www.vision2030.gov.jm/Portals/0/NDP/Vision 2030 Jamaica NDP Full No Cover (web)

[4] Ministry of Health & Wellness Jamaica, Strategic Business Plan 2018/2019-2020/21

[5] United Nations. Sustainable Development Goals [Internet]. 2015. Available from: https://sustainabledevelopment.un.org/?menu=1300

[6] Pan-American Health Organization. Sustainable Health Agenda for the Americas 2018-2030. 2017.

CONTEXT

Health is essential to human capital development and therefore key to national development and social wellbeing. Jamaica's growth and the macroeconomic situation operate within the context of the Jamaica Vision 2030 Jamaica - National Development Plan (Vision 2030 Jamaica). Jamaica is classified by the World Bank as an upper middle-income country, however for decades the country has struggled with low growth, high public debt and many external shocks that have weakened the economy. The implementation of comprehensive reform programmes has resulted in improvements in most of the indicators for economic and social development[7].

Jamaica's Human Development Index is 0.732— which put the country in the high human development category— positioning it at 97 out of 189 countries and territories[8]. Fifty-four percent of the population resides in urban areas. Though on the decline, Jamaica continues to grapple with issues relating to poverty and unemployment, which contributes to the inequity in some health outcomes. In 2015, the gross enrollment rates for pre-primary, primary, secondary and tertiary institutions in the public and private education systems were 99.8%, 99.4%, 97.3% and 28.3 % respectively[9].

Jamaica remains vulnerable to natural and human-induced hazards, such as hurricanes, earthquakes, floods, storm surge, drought and fires, and their related impact on the social and economic fabric of society. This vulnerability is one of the greatest challenges to the achievement of sustainable development. This is compounded by social issues such as poverty, the location of human settlements in high-risk areas, environmental degradation and instances of poorly constructed infrastructure and housing. The island's coral reefs, highland forests and mangroves are also vulnerable to climate change.

The health sector has celebrated numerous successes in health and the prevention, management and control of diseases. Improvements in life expectancy and the steady decline in infant and under-5 mortality attest to the efforts of the people and the consistent policies of governments throughout time, however, challenges still remain.

[7] Planning Institute of Jamaica. Economic and Social Survey Jamaica 2015: Overview [Internet]. 2015. Available from: http://webstore.pioj.gov.jm/images/PreviewDocument/20243.pdf
[8] United Nations Development Programme. Human Development Reports [Internet]. 2016. Available from: http://hdr.undp.org/en/composite/GDI
[9] Planning Institute of Jamaica. Economic and Social Survey Jamaica 2015: Overview [Internet]. 2015. Available from: http://webstore.pioj.gov.jm/images/PreviewDocument/20243.pdf

Jamaica is experiencing both a demographic and epidemiological transition with the double burden of communicable diseases and non-communicable diseases (NCDs). Twelve percent of the population are older persons (60 years and over), with the proportion of older persons projected to increase to 16.8% by 2025[10].

The risk factor burden is increasing with 1 in 3 persons having at least one chronic disease while the prevalence of comorbid conditions among those with a chronic illness have also increased. Maternal mortality rate has remained high, and new and emerging diseases such as Chikungunya, Zika, and Dengue continue to threaten population health. In contrast, utilization of public health care services is declining and in recent years the average length of stay and death rates in hospitals increased[11].

Violence and injuries continue to place a burden on the health system. Violence is the second leading cause of death in the age group 35 to 45, accounting for 1 out of 10 deaths in this age group. Road traffic fatality rates remain high with 80% of the fatalities each year being male[12].

Within the health systems, there are issues with efficiency in the areas of health worker distribution, coordination of care, hospital bed capacity, maintenance of equipment, as well as potentially unnecessary/low quality care, and administrative inefficiency.

Over time there have been difficulties in keeping health facilitates well-resourced and responsive to the new challenges of the twenty-first century. While the first level of care (FLC) provides a broad range of services from preventative, promotive, curative, personal and non-personal public health services, there is fragmentation in the delivery of these services with respect to governance, referrals between levels of care, limited access to some services such as diagnostic and specialty services, insufficient human resources for health especially in remote areas and limited community participation and inter-sectoral coordination in the delivery of care. These issues have contributed to the noted decline in the utilization of health centers since 2010, with an associated increase in the utilization of the Accident & Emergency departments of hospitals as the first point of contact with the healthcare system resulting in overcrowding in the emergency departments and waste of resources.

The Jamaican health system has also been challenged by decreasing fiscal space due to low economic growth and a high debt burden. By almost every measure, public health expenditure has increasingly lagged behind comparator countries, and remains below levels recommended to achieve Universal Health. Given the limited fiscal space for health, improving the efficiency and equity of public health expenditures is important.

While public health spending is generally pro-poor, and despite the removal of user fees, out-of-pocket expenditures (OOPS) remain high at 28 percent and insurance coverage rates are below 20 percent. OOPS as a share of total health expenditures continues to be slightly above the median when benchmarked against comparator countries.

The HR structure of the Ministry of Health & Wellness, developed in the 1970s, has not been reviewed and upgraded in response to changes in the demographics and epidemiology over the years. This has resulted in increased staff costs because of inefficient employment arrangements. New services have been added at different levels without appropriate HR planning. All of which results in a challenged HRH system.

Various inefficiencies have been identified in the current structural arrangements of the MOHW and the RHAs necessitating a revision of roles, functions and responsibilities of these entities. The institutional arrangements that govern service delivery are challenged by poor reporting requirements, performance targets set on an ad hoc basis, and a lack of action for noncompliance with reporting or missed targets. Three-year Service Level Agreements (SLAs) between the MOHW and the RHAs are reviewed and updated annually but are not utilized to their full potential. Weaknesses in these institutional arrangements impact the ability of the MOHW to make decisions or allocate resources on the basis of need and performance and respond to health issues as they emerge.

In this challenging context, a new Strategic Agenda for the health sector, focused on correcting deficiencies and transforming key areas, can reverse the downward trends and accelerate the move toward universal access to health and universal health coverage in Jamaica.

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[10] Statistical Institute of Jamaica. Population Census 2011 [Internet]. 2011. Available from: http://statinja.gov.jm/census/popcensus/popcensus2011index.aspx

[11] Ministry of Health & Wellness Jamaica. Jamaica Health and Lifestyle Survey III [Internet]. 2018. Available from: https://www.MOHW.gov.jm/wp-content/uploads/2018/09/Jamaica-Health-and-Lifestyle-Survey-III-2016-2017.pdf

[12] Ibid 11

STRATEGIC FRAMEWORK

Vision 2030 Jamaica introduces a new paradigm which redefines the strategic direction for Jamaica. It puts Jamaica on a different path – a path that will lead to sustainable prosperity. The central challenge for the country's national development is to create the conditions in which the productive enterprises are able to generate greater levels of wealth and in which the social and environmental conditions and the general well-being of the society are enhanced[13].

Sustainable prosperity for Jamaica is about the people, their families and communities, the society and economy, and it is clearly embodied in the vision: "Jamaica, the place of choice to live, work, raise families and do business". The challenges to achieving the Vision are significant, however, to achieve this vision Jamaica is required to secure sustained and broad-based improvement in the quality of life.

The health of the nation reflects the level of social and economic development, the choices made by Government and the people to promote and protect health, to manage illnesses and specific health problems, and to respond adequately to public health emergencies. Jamaica has achieved many milestones in health, yet, our central challenge today, is how to ensure that all Jamaicans, regardless their socio-economic condition, their age, their gender, can be empowered to achieve their fullest potential in health, leaving no one behind. As a Nation, bold decisions and choices have to be made in order to respond to the current health needs and safeguard future generations. A new paradigm to transform health and health care delivery is needed.

The Ministry of Health & Wellness is committed to drive the necessary changes "to ensure the provision of quality health services and promote healthy lifestyles and environmental practices" to achieve our vision: "Healthy People, Healthy Environment".

VISION

HEALTHY PEOPLE,
HEALTHY ENVIRONMENT

MISSION

TO ENSURE THE PROVISION OF QUALITY HEALTH SERVICES AND TO PROMOTE HEALTHY LIFESTYLES AND ENVIRONMENTAL PRACTICES

[13] Vision 2030 Jamaica, page 47

GUIDING PRINCIPLES

This Vision for Health 2030 Plan aligned with the Nation's first long-term Vision 2030 Jamaica - National Development Plan is based on the following guiding principles:

Equity - Striving for fairness and justice by eliminating differences that are unnecessary and avoidable.

Integrity-Ensuring transparent, ethical, and accountable performance.

Respect-Embracing the dignity and diversity of individuals and groups

Collaborative -The application of collective experience and knowledge of internal and external partners that responds to shared challenges and goals.

Responsive - Anticipating change and taking relevant actions that make a difference and achieve positive results.

Transformational Leadership-Ownership of, and championing the change required to achieve the vision for the health sector.

Based on a shared vision for health and nationally accepted values and principles, the Vision for Health 2030 Plan will guide the transformation and development of the system, its services and benefits in line with the mission statement of the Ministry of Health and the National Vision for the development of our country. The Vision for Health 2030 Plan embraces the results-based management framework established in the SDGs and the Vision 2030 Jamaica framework.

The Vision for Health 2030 Plan embraces the progressive realization of universal access to health and universal health coverage as a central approach. This will enable the consolidation of advances in maternal and child health and control of communicable diseases, reduce the burden of chronic diseases with innovative models of care that include prevention and health promotion, as well as reduce gaps in the access to and utilization of health services.

Aligned with the Vision 2030 Jamaica - National Development Plan and by extension the Sustainable Development Goals, the Strategic Plan aims to improve the health and well-being of the population through eight health impact goals until 2030:

i. **ENSURE A SAFE MOTHERHOOD AND A HEALTHY START FOR NEWBORNS AND INFANTS;**

ii. **IMPROVE THE HEALTH OF THE POPULATION WITH AN EMPHASIS ON REDUCING MORTALITY, MORBIDITY AND DISABILITY RELATED TO NCDS AND THEIR RISK FACTORS;**

iii. **REDUCE MORTALITY, MORBIDITY AND DISABILITY DUE TO COMMUNICABLE DISEASES;**

iv **REDUCE MORTALITY, MORBIDITY AND DISABILITY DUE TO POOR QUALITY OF HEALTH CARE;**

v **ELIMINATE PRIORITY COMMUNICABLE DISEASES, INCLUDING AIDS, TUBERCULOSIS, MOTHER-TO-CHILD TRANSMISSION OF HIV, AND CONGENITAL SYPHILIS;**

vi **ELIMINATE NEGLECTED INFECTIOUS DISEASES AS PUBLIC HEALTH PROBLEMS;**

vii **REDUCE THE NUMBER OF CASES OF DEATH, DISABILITY, AND ILLNESS, WITH EMPHASIS ON PROTECTION OF THE POOR AND VULNERABLE POPULATIONS AFFECTED BY EMERGENCIES AND DISASTERS;**

The Vision for Health 2030 Plan sets the agenda for change by laying out six (6) strategic goals and providing a framework for aligning strategic outcomes, outputs and key actions. It supports the attainment of health impact through the achievement of outcomes such as the integration of health services and the promotion of healthy behaviors. Therefore, it provides a comprehensive and strategic framework for the alignment of the different stakeholders towards reaching common national targets.

The six strategic goals conceptualized to achieve the vision of the MOH for 2030 are:

- **Strategic Goal 1:** Safeguarding access to equitable, comprehensive and quality health care
- **Strategic Goal 2:** The stewardship capacity of the Ministry of Health is strengthened to improve leadership and governance to achieve universal access to health and universal health coverage Strategic Goal 3: Increased and improved health financing with equity and efficiency
- **Strategic Goal 4:** Ensuring human resources for health in sufficient number and competencies, committed to the mission
- **Strategic Goal 5:** Social participation and inter-sectoral collaborations to address the social determinants of health.
- **Strategic Goal 6:** Making reliable and modern infrastructure available for Health Service Delivery

Because of its strategic nature this document plots the strategic goals and outcomes of Vision for Health 2030 Plan with the understanding that planning for outputs and activities of operational nature will be conducted on a yearly basis making the needed adjustments dictated by changes during the execution period and aligned with the national planning cycles.

Successful implementation of the Vision for Health 2030 Plan will depend significantly on four factors: the achievement of a national commitment, planning and financial alignment, flexibility, and constant monitoring and evaluation. The success of Vision for Health 2030 Plan will be measured by the Ministry of Health's contribution to the attainment of the health impact goals measured by their corresponding indicators.

STRATEGIC GOALS

STRATEGIC GOAL 1
SAFEGUARDING ACCESS TO EQUITABLE, COMPREHENSIVE AND QUALITY HEALTH CARE

RATIONALE

Comprehensive, equitable and quality health services are essential for promoting and realizing the right to the enjoyment of the highest attainable standard of health. Consequently, in equitable health systems, these services should be available to all people, with no difference in quality and without distinction of their economic or social condition. Furthermore, these services should be designed with due regard to the differentiated and unmet needs of all people and the specific needs of groups in conditions of vulnerability. Moving toward equitable, comprehensive, quality healthcare services, in accordance with health needs and priorities, system capacity, and national context will require planned, concerted and sustained efforts.

Jamaica observed important achievements in health in the last three decades. However, significant challenges remain:

- **Over the last 10 years, a 25 to 30% increase in disability and deaths caused by diabetes, cerebrovascular diseases, heart diseases and chronic kidney diseases has plagued the system and its resources.**
- **We are struggling with a high rate of accidents and injuries. Overall, injuries and violence are associated with a 4% increase in disability adjusted life years over the last 10 years and interpersonal violence represents the 8th leading cause of disability.**
- **Jamaica also faces additional threats from new and recurring communicable diseases including Tuberculosis, Chikungunya, Zika and Dengue, as well as challenges in immunization rates. On the side of good news, the trends in HIV and AIDS cases and deaths have been decreasing steadily over the last 10 years.**
- **Despite past successes, challenges remain in maternal-child health and environmental health. Of high concern is the stagnation in the downward trend of maternal mortality and under-five mortality rates.**

The triple burden of health challenges affecting Jamaicans (injuries, communicable and non-communicable diseases) is of epidemic proportions with significant human, social and economic consequences, including the huge financial cost of treating these conditions in a curative oriented system.

There are also important concerns in regards to equity and health services utilization. Clear differences in the socioeconomic levels of those seeking care in public facilities has been documented. In 2014, 26% of those who used public facilities were from the poorest quintile of the population, compared to only 13% for those from the richest quintile, a two-fold difference[14]. There are also important differences by income quintile in other relevant preventive indicators, such as: the proportion of women receiving at least 4 antenatal visits, the number of children with early initiation of breastfeeding, and in immunization coverage of children. This points strongly to the need to pay close attention to barriers to access to health, which is not always related only to income.

To strengthen access and equitable health care delivery, Jamaica needs to implement an Essential Package of Health Services based on the epidemiological profile of the country, and organized by population group: Childhood, Pregnant Women, Adolescents, Adults and the Elderly - adults over 60 years of age. This is a best practice in many developing countries, aiming to achieve UHC.

[14]Jamaica Survey of Living Conditions (JSLC) 2014

At minimum the package is to include free access to the following services: endemic tropical diseases; chronic disease management; ambulatory patient; emergency; hospitalizations; maternity and new-born care; mental health including behavioural health; environmental health; nutrition; substance use disorder services; prescription drugs; rehabilitative services and devices; diagnostic services; paediatric services, including vision and oral care; chronic disease management; long-term care for the elderly; golden age home care in collaboration with the social welfare sector; health education in topics such as obesity management, healthy eating, child abuse and tobacco.

The health care delivery services in Jamaica is hospital-centric with inefficiencies produced as hospitals engage in providing services to patients that can be more effectively provided at the FLC. Although there is an island-wide network of health centres categorized according to the level of care offered, they are underutilized due to issues with service availability and accessibility as well as a decided preference amongst the populace to use hospitals as the first point of care. There is a need for greater coordination between the levels of care as the referral system is not effectively utilized leading to inefficient use of resources and an added burden on secondary care facilities. Currently hospitals are overcrowded with patients who could be more cheaply treated in smaller facilities. Efficiency gains and improved access to care will be enhanced through a well-functioning referral system.

Worldwide, hospitals are undergoing essential changes in the way they are organized, managed and the services they provide. Parallel to new investments in hospital infrastructure and equipment, there is urgent need to re-orient the role of hospitals and modernize their management to improve response capacity, efficiency and health outcomes while increasing quality and patient safety.

Furthermore, there is growing emphasis on patient-centric health care where partnerships are established amongst health care professionals, patients and their families to align with the patients' wants, needs and expectations for better health outcomes. Within such a system, the quality of interaction between the health care practitioner and patient and family as well as the manner in which care is provided becomes crucial.

To respond to these challenges, Jamaica's health system will need to improve and sustainably ensure access to comprehensive, quality, first level of care services with strong competencies for promoting healthy lifestyles and prevention, early detection, managing and controlling chronic conditions, and the prevention of complex complications that lead to premature deaths. A first level of care supported by specialized services, including hospitals, with optimal use of and coordination between both, public and private providers is therefore essential.

LIFE-CYCLE APPROACH

The implementation strategy for each age group, based on the Life -cycle approach, will be based on WHO technical guidelines, state-of-the art clinical protocols, and internationally recognised best practices. Operations Research techniques are required to determine how to best organize service provision based on the clinical requirements and protocols for each phase of the Life cycle. Below is a summary of the technical guidelines for each stage of the life cycle[15].

Childhood: The WHO/UNICEF guidelines for Integrated Management of Childhood Illness (IMCI) offer simple and effective methods to prevent and manage the leading causes of serious illness and mortality in young children. The clinical guidelines promote evidence-based assessment and treatment, using a syndrome approach that supports the rational, effective and affordable use of drugs. The guidelines include methods for checking a child's immunization and nutrition status; teaching parents how to provide treatments at home; assessing a child's feeding and counselling to solve feeding problems; and advising parents about when to return to a health facility. The approach is designed for use in outpatient clinical settings with limited diagnostic tools, limited medications and limited opportunities to practice complicated clinical procedures. In each country, the IMCI clinical guidelines are adapted: 1) to cover the most serious childhood illnesses typically seen at first-level health facilities; 2) to make the guidelines consistent with national treatment guidelines and other policies, and 3) to make the guidelines feasible to implement through the health system and by families caring for their children at home.

Pregnant Women: The WHO/UNFPA/UNICEF guidelines provide guidance for the integrated management of pregnancy and childbirth: "Managing complications in Pregnancy and Childbirth, A Guide for Midwives and Doctors." In support of the Safe Motherhood Initiative, the WHO "Making Pregnancy Safer Strategy" focuses on the Health Sector's contribution to reducing maternal and newborn deaths. In addition, the Integrated Management of Pregnancy and Childbirth (IMPAC) is the technical component of the aforementioned strategy and mainly addresses the following: 1) Improving the skills of health workers through locally adapted guidelines and standards for the management of pregnancy and childbirth at different levels of the health care system;

[15] Refer to Annex I for a chart presenting the primary, secondary and tertiary services by age group.

2) Interventions to improve the health care system's response to the needs of pregnant women and their newborns, and to improve the district level management of health services, including the provision of adequate staffing, logistics, supplies and equipment; 3) Health education and promotion of activities that improve family and community attitudes and practices in relation to pregnancy and childbirth.

Adolescents: Technical guidelines are provided in the "Global Accelerated Action for the Health of Adolescents (AA-HA!)" to support country implementation for coming of age of adolescent health within global public health. More than 3000 adolescents die every day from largely preventable causes such as unintentional injuries; violence; sexual and reproductive health problems, including HIV; communicable diseases such as acute respiratory infections and diarrheal diseases; non-communicable chronic diseases, poor nutrition, substance use and suicide. Even more suffer from ill health due to these causes. Although much research is still needed, effective interventions are available for countries to act now.

Adults: The WHO Package of Essential Non-Communicable Chronic Disease (NCCD) Interventions for primary care in low-resource settings is an innovative and action-oriented response to the above challenges. Efficient use of limited health care resources, sustainable health financing mechanisms, access to basic diagnostics and essential medicines and organized medical information and referral systems are imperative for provision of equitable care for people with and at risk of NCCD. They require long-term care that is proactive, patient centered, community based and sustainable. Such care can be delivered equitably only through health systems based on primary health care. The WHO package is the minimum standard for NCCD to strengthen national capacity to integrate and scale up care of heart disease, stroke, cardiovascular risk, diabetes, cancer, asthma and chronic obstructive pulmonary disease in primary health care in low- resource settings

Elderly: Effective community-based primary care is essential in order to support healthy ageing. Many of the priorities for adults remains in this cycle, with particular emphasis on the prevention and care of chronic diseases. Expenditure on health increases significantly in this stage, and it is therefore imperative that health is addressed in conjunction with social care. Mental health is of equal priority for the elderly. There are three subsets to healthy ageing that must be provided for to ensure comprehensive health of the elderly. These subsets are: healthy biological ageing, defined as defined as the "maintenance, post maturity, of optimal physical and cognitive functioning for as long as possible, delaying the onset and rate of functional decline" Functional ageing is the cognitive and physical capabilities to carry out essential tasks on a daily basis, and wellbeing can be viewed as positive emotional health, engaging in meaningful societal relationships, leading a meaningful life and maintaining independence.

GOAL 1-STRATEGIC OUTCOMES

	STRATEGIC OUTCOMES	STRATEGIC ACTIONS
1.1	Strengthened Primary Care facilities through implementation of the Standard Comprehensive Essential Benefits Package in a revised and renewed Primary care model in all Health Centres and Health Departments by 2030.	Develop an essential benefit package that meets the identified needs of the population based on epidemiological and environmental profiles and in line with the social and economic forecast.
		Transform structures and functions of health centers and health departments to effectively serve as the gateway to modern health services, procure the necessary equipment and new technologies, including green technologies and safe health facilities standards, and increasing their capacity to respond to population needs and demands
		Reorganize primary health care centres to a three-tiered system (community, district and comprehensive) with strengthened and streamlined referral and linkage systems that offers a more equitable and a higher level of care/services based on demographic and health needs than the existing five-tiered system (See Annex 2 for proposed structure).
		Create new and expand existing national programmes that encourage community based involvement in health care provision.
1.2	All hospitals, specialized care centres and support services are modernized to provide efficient and quality service in an aesthetically pleasing environment	Identify, upgrade and improve key infrastructure in hospitals and support facilities to improve efficiency and meet the demands of the population including the establishment of Centres of Excellence for mental health, cardiology, neurology, oncology and nephrology.
		Establish new facilities to increase capacity and meet new demands of the population. This includes the building of the Child and Adolescent Hospital in Western Jamaica.
		Develop and implement a transformation plan for hospitals and support services in line with modern technology and management standards.
		Implement telemedicine to improve access to health care.
		Strengthen management competencies and the adoption of modern tools for management of hospital and allied services through training and recruitment and development of continued education programme.
		Develop and implement a quality assurance programme to assess and support the delivery of health services in all public facilities

STRATEGIC GOAL 2

THE STEWARDSHIP CAPACITY OF THE MINISTRY OF HEALTH & WELLNESS IS STRENGTHENED TO IMPROVE LEADERSHIP AND GOVERNANCE TO ACHIEVE UNIVERSAL ACCESS TO HEALTH AND UNIVERSAL HEALTH COVERAGE

INTRODUCTION

The leadership and governance of health systems, also called stewardship, is arguably the most complex but critical building block of any health system. It is about the role of the government in health and its relation to other actors whose activities impact on health to oversee and guide the whole health system, private as well as public, in order to protect the public interest. Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability[16].

The Government of Jamaica has expressed, at the highest level, its commitment to Universal Access to Health (UAH) and Universal Health Coverage (UHC). Pursuant to this commitment to UAC and UHC, the Ministry of Health & Wellness is steadfastly pursuing the achievement of both. Strengthened stewardship and governance is essential to achieving and sustaining UAH and UHC. In fact, the World Health Organization's Strategy for Universal Access to Health and Universal Health Coverage[17] outlines the strengthening of stewardship and governance as a strategic line of action. This Strategic line of action calls on member states to inter alia, strengthen the stewardship capacity of national authorities, ensuring essential public health functions and improving governance to achieve universal access to health and universal health coverage; strengthen national information systems in order to conduct monitoring and evaluate progress towards UAC and UHC; evidenced based decision making; and a legal and regulatory framework which reflects national commitment to UAC and UHC.

The strengthening of the leadership role of the MOHW in Jamaica requires the consideration of political, technical and human resource capacity. The MOHW is mainly responsible for providing stewardship in the formulation of health policies, planning and evaluation of health programmes and the monitoring and evaluation of health outcomes at the national level. This responsibility goes beyond the public sector and requires strong technical capacities and leadership to effectively exercise the role of national health authority.

Planning for health in Jamaica must involve all stakeholders in order to obtain alignment and commitment to a vision that is shared by all. Commitment leads to ownership and accountability. Again, the responsibility goes beyond the public sector and requires strong planning competencies and technical know-how for effective implementation at national, regional and parish levels.

To this respect, the Vision for Health 2030 Plan focuses on achieving the strengthening of capacities in the MOHW for effective leadership, alignment of planning and coordination of resources, and the capacity to generate, utilize and disseminate information for decision-making and transparency.

[16] WHO (World Health Organization). Everybody's business: Strengthening health systems to improve health outcomes, WHO's framework for action. Geneva: World Health Organization; 2007.
[17] Pan American Health Organization Strategy for universal access to health and universal health coverage; 53rd Directing Council (CD53/5, Rev. 2); Washington DC: Oct, 2014

RATIONALE

The recent report on the Assessment of the Public Healthcare Delivery Services in Jamaica undertaken by the Pan American Health Organisation (PAHO)[18] and the report on the Review of Public Health Expenditures[19] undertaken by the World Bank outlined several deficiencies in the stewardship and leadership capacity of the Ministry of Health & Wellness. These deficiencies include:

1. Health Planning: Inadequate capacity for health planning at the level of the Ministry of Health & Wellness and at the level of the Regional Health Authorities (RHAs) which has resulted in poor implementation of health polices and plans; ad hoc development of policies and unplanned and unfunded programs to meet perceived health care needs of the communities, leading to inefficiencies, inequities and improper financial management; development of sub-plans that are not aligned with a national vision for health; and lack of stakeholder buy-in and ownership.

2. Ability to develop evidence-based policy and monitor outcomes: Development of evidence-based policy requires a concerted emphasis by the MOHW on the quality of data, production, and utilization of analytical reports. Comprehensive reporting on selected health indicators, including utilization and accessibility of health services, as well as reporting of information obtained from the performance indicators of the SLAs as part of strengthening the accountability of RHAs is recommended.

3. Structure of RHAs: A need to simplify organizational arrangements reorienting towards health outcomes instead of financial and administrative outputs; centralization of certain functions and outsourcing of certain ancillary general services to improve efficiency. An apparent lack of accountability and monitoring and evaluation at the RHA level. This hampers evidence-based decision making efforts at the RHA level and at the MOHW, and consequently, policy decisions may not be fully informed.

4. Service Level Agreements (SLAs): the institutional arrangements that govern service delivery are challenged by poor reporting requirements, performance targets set on an ad hoc basis, and a lack of action for noncompliance with reporting or missed targets. This impacts the ability of the MOHW to make decisions or allocate resources on the basis of need and performance, and respond to health trends as they emerge. The monitoring and evaluation of health outcomes and health system performance is weak due to inadequate capacity of the MOHW to consistently analyze health data, infrequent development of SLAs, difficulty in measuring targets and the use of outdated SLAs.

[18] Pan-American Health Organization. Assessment of the Public Healthcare Delivery Services in Jamaica. 2017.
[19] World Bank. Jamaica Review of Public Health Expenditure. 2017.

GOAL 2-STRATEGIC OUTCOMES

	STRATEGIC OUTCOMES	STRATEGIC ACTIONS
2.1	Effective Stewardship and Governance of the Health Sector at all levels	Improve the capacity to implement the Essential Public Health Functions
		Update and modernize health policies, legislations and regulations
		Strengthen institutional regulatory capacity for the enforcement health polices and laws
		Implement an effective and sustainable mechanism for the systematic review and updating of health, policies, laws and regulations
		Enhance institutional regulatory mechanism for the registration and licensing of health professionals and health services providers
		Implement a Monitoring and Evaluation Framework throughout the MOHW, its departments and agencies
		Implement a Risk Management Framework and Strategies throughout the MOHW, its departments and agencies
		Within the framework of the Health in All Policies (HiAP) approach, improve partnerships with other government ministries, communities, non-governmental organizations, civil society and international community.
2.2	Efficient and effective organizational and management structure of the public health system	Modernize and restructure the Ministry of Health & Wellness through the Public Sector Modernisation Programme
		Implement an effective and sustainable mechanism for the systematic strengthening of management and leadership capacity in the MOHW and introduction of programmes for the continuous development of new technical competencies
		Rationalization of the structure of the Regional Health Authorities
		Develop and implement a Customer Service Improvement Plan throughout the public health sector
		Establish effective Service Level Agreements and ensure that they are systematically monitored to drive accountability, quality and performance
		Develop and implement a Public Private Partnership Strategy throughout the MOHW, its departments and agencies

	STRATEGIC OUTCOMES	STRATEGIC ACTIONS
2.3	Evidenced –based policy, planning, implementation, monitoring and evaluation	Institutionalise results-based planning and budgeting and align to MOHW strategic goals with formalized mechanisms for prioritization during the ten-year execution of Vision for Health 2030
		Institutionalize Health Technology Assessment
		Develop and implement a funded Health Research Agenda to generate evidence to guide policy-making and monitoring and evaluation
		Systematic publication on the performance of the health system.
		Strengthen institutional capacity to ensure the availability of accurate health data for analysis and decision making
2.4	Strengthened National Health Information Systems	Effective implementation of the MOHW's Plan of Action for Information's Systems for Health (IS4H)
2.5	Full implementation of the eight core capacities[20] of the International Health Regulations and full compliance with legal requirements for reporting to the mandatory notification systems.	Strengthen surveillance
		Compliance with legal requirements

[20] The International Health Regulations eight core capacities are: national legislation, policy & financing; coordination & NFP communications; surveillance; response; preparedness; risk communication; human resources and laboratory.

STRATEGIC GOAL 3
INCREASED AND IMPROVED HEALTH FINANCING FOR EQUITY AND EFFICIENCY

RATIONALE

Health financing as a core function of a health system includes decisions on sources of revenues for the health sector, pooling arrangements and how to allocate those resources to pay for health services that should be guaranteed to the population. Addressing all three, health financing functions comprehensively and in alignment with the other health systems functions is a necessary condition for moving towards Universal Health.

Current health financing sources

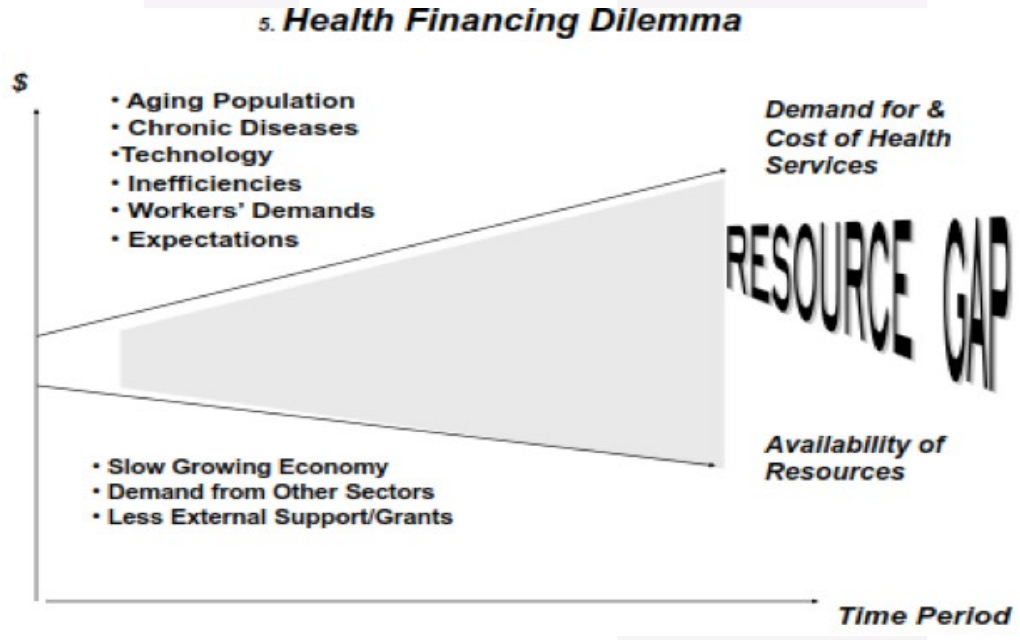
Total health financing consists of the following four main sources:

- Government taxes,
- Out of pocket payments,
- Pre-paid plans/health insurance,
- External aid and support.

There is a health financing dilemma faced by most countries, that is, the resource gap between demand for health care service and cost of providing those services versus the available resources. This dilemma is depicted in Figure 3.1:

Currently, public expenditure in health in Jamaica represents 3.47% of GDP (of which the MOHW is responsible for the bulk (97%), financed primarily through taxes), Figure 3.2. International experience has shown that a 6% of GDP as public expenditure in health is a useful benchmark and a necessary condition to achieve Universal Health. Therefore, Jamaica needs to close that 2.53 percentage point gap with the international benchmark.

FIGURE 3.1



Source: Stanley Lalta, Presentation at PAHO/WHO Workshop Barbados, 22-23 October 2012

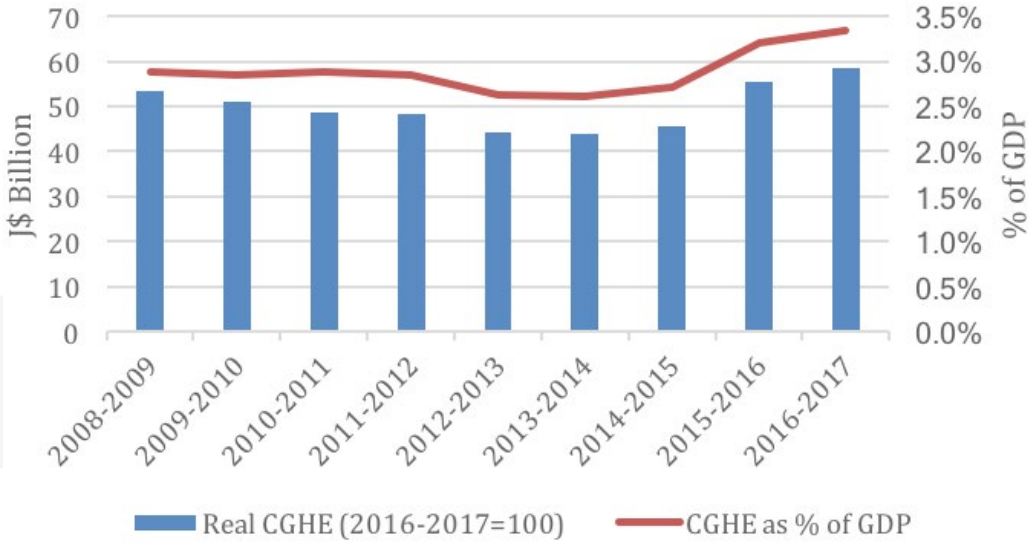
Further, if the Government of Jamaica (GOJ) maintains the current trend in public health investment levels between 2.0 - 3.4% as obtained in the recent 20 years it will take 80 years to reach the public expenditure in health (PEH) target of 6% GDP. However, in a scenario where GOJ increases real term allocations to health with 12.4% annual increase rates, Jamaica would be able to accomplish the WHO target on PEH on 6% of GDP on a significant shorter time horizon.

On the other hand, Out-of-Pocket (OOP) spending in health represent 28% of the total expenditure in health. (Figure 3.3) Although this has been decreasing over the last two decades, it is still at relatively high levels. OOP spending constitutes the second largest source of financing for health care provision in Jamaica. International experience has shown that when OOP expenditure is above 20%, families are at a greater risk of catastrophic health spending and impoverishing because of an episode of illness.

Jamaica is experiencing problems also in the way funds are pooled for health with significant segmentation. Private health insurance constitutes the third biggest finance source of health care expenditure. Based on the 2015 Jamaica Survey of Living Conditions (JSLC) approximately 19% of the population have private health insurance, with the largest proportion of those with health insurance being in Quintile 5 (40.3 per cent) and lowest being in Quintile 1, 3.7% (Figure 3.4). Although the prevalence of NCDs in the poorest and richest quintiles were marginally similar at 22.4% and 30.2%, respectively, only 3.7% of the poorest quintile had any kind of health insurance compared with 40.3% of the richest quintile. Consequently, the poor are likely to be disproportionately affected by catastrophic health expenditures.

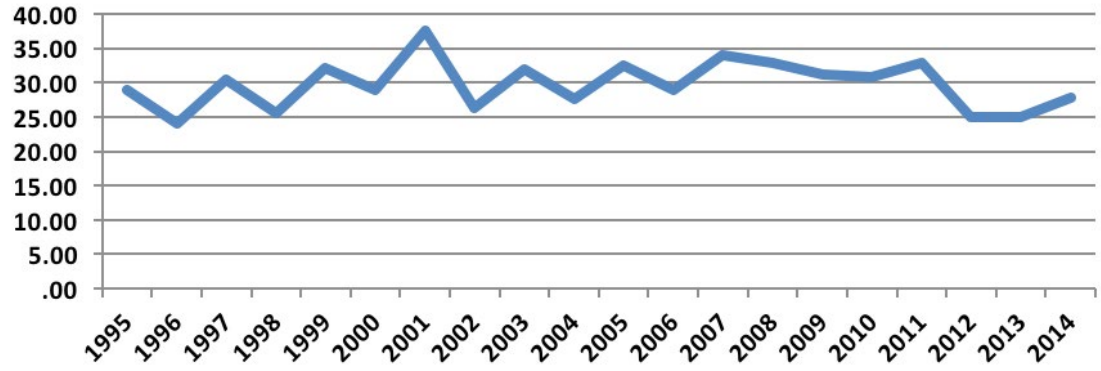
There also exist another 25% (approximately 500,000) of Jamaicans that have disease-specific coverage under the National Health Fund. Enhancing and extending pooling of funds increases equity and efficiency. Health systems with larger and more inclusive pooling mechanisms are more efficient in the distribution of risk and less costly per capita than those with smaller fragmented pools.

FIGURE 3.2 TRENDS IN CENTRAL GOVERNMENT HEALTH EXPENDITURE, 2008-2009 TO 2016-2017



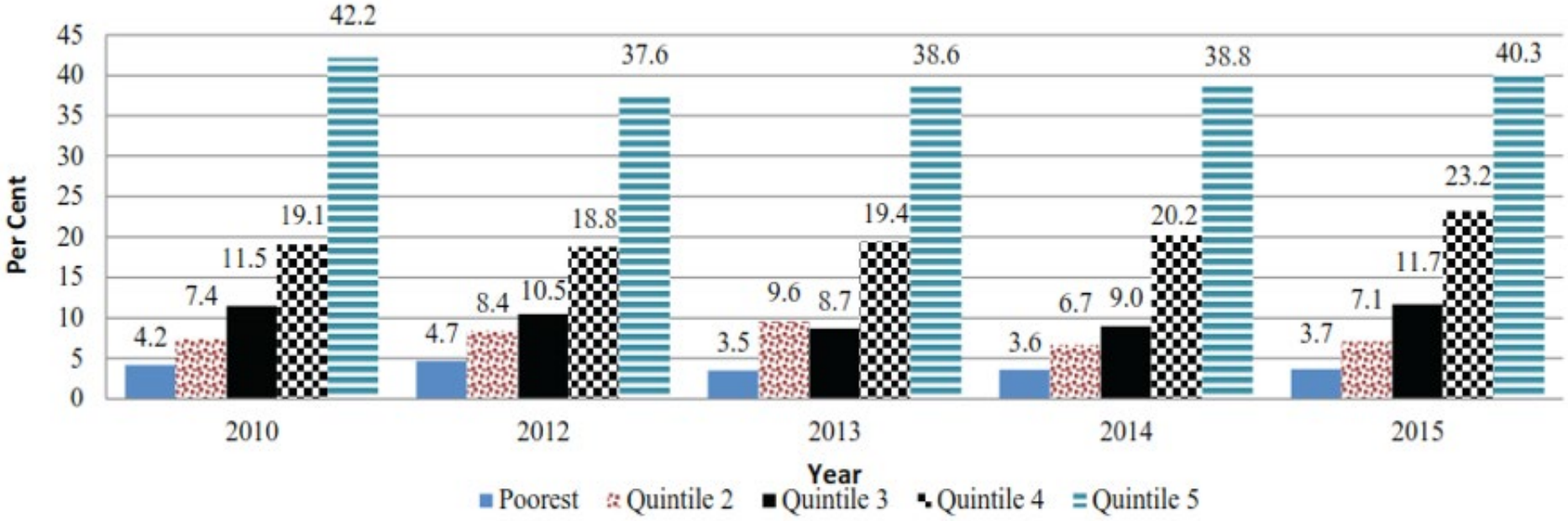
Source: World Bank Expenditure Review

FIGURE 3.3 JAMAICA: OUT OF POCKET EXPENDITURES AS SHARE (IN %) OF TOTAL HEALTH FINANCING,1995- 2014



Source: WHO data bank

FIGURE 3.4 HEALTH INSURANCE COVERAGE BY QUINTILE, 2010–2015



Source: Jamaica Survey of Living Conditions, 2015

AFFORDABILITY OF HEALTH CARE REMAINS A BARRIER FOR 15.1% OF JAMAICANS

The allocation of funding also faces challenges. Allocation of resources should reflect health systems priorities and goals, and payment mechanisms should be conducive to incentivizing the provision of services that are prioritized by the country. Currently, the allocation of resources across the Regional Health Authorities (RHAs) does not seem to reflect defined technical criteria.

With respect to levels of care, the prioritization of the first level of care has decreased, with all the RHAs well below the originally agreed 30% allocation. In addition, allocation through historical global budgets is predominant within the public sector, with low incentives towards improving efficiency and quality.

Table 3.1 below depicts some examples of the factors that contribute to the inefficiencies in the health system. The inefficiencies identified are amenable to change either directly or indirectly by reforming the country's health financing mechanisms.

The achievement of the National Targets in health established in the Vision 2030 Jamaica will require a higher fiscal prioritization for health and significant transformations in the manner in which health funds are pooled and allocated. There is a need to achieve levels of financial resources sufficient for the health system to provide comprehensive, quality health for all Jamaicans, regardless of socio-economic status, geographic residence, and other characteristics.

TABLE 3.1 INEFFICIENCIES IN THE HEALTH SYSTEM

INDICATOR	ISSUE
PHYSICAL INPUTS (E.G. PERSONNEL, INFRASTRUCTURE)	
Health worker density	Health worker density is poorly aligned with hospital admissions and number of health center visits
Bed occupancy rate (BOR)	Hospital bed rates relative to population size are low, but largely function at excess capacity
Equipment that is purchased and cannot be repaired or is not used optimally	Medical equipment is poorly maintained and there are insufficient funds for maintenance more generally
OUTPUTS AND OUTCOMES	
Average length of stay (ALOS)	ALOS appears to be increasing in contrast to global trends
Mortality rate in hospitals	Death rates appear to be increasing, suggesting a decline in the quality of care
Maternal mortality	Maternal mortality rates appear to have increased since 1990
HEALTH FINANCING AND HEALTH SYSTEM ORGANIZATION	
Budgeting process used - how does this affect providers/purchasers ability to allocate resources to be in line with priorities	Budgeting among the RHAs is based on historical trends, and not linked to need or performance.
Fragmentation in the broader health system	There is no integrated care system, which is increasingly important given the growing share of the population with chronic diseases

Source: The World Bank.

Jamaica has made important strides in attempting to reduce segmentation, extend coverage and ensure equity. However, a large percentage is still left behind in matters of access, quality of care and equity. There is a national consensus on the need and possibilities of a national insurance scheme that improves equity for all Jamaican. The current proposition is for a National Health Insurance Scheme to be implemented making an efficient use of public and private providers through a phased approach to finance the delivery of a Package of Services based on the identified needs of the population, epidemiological profiles and in line with the social and economic forecast. The logistics of this Scheme inclusive of structure, direct and indirect financing mechanisms (formal and informal contributions, taxes, PPP), the role of private health insurance, co-payments, and government subsidies for vulnerable groups is currently being deliberated at the national level.

Jamaica achieved an important milestone to remove financial barriers to accessing health services and provide financial protection for health in 2008 by removing user fees at the point of care in public health services, to maintain this important achievement and address current and future health needs of the population, it is necessary to secure sustainable financing.

GOAL 3-STRATEGIC OUTCOMES

	STRATEGIC OUTCOMES	STRATEGIC ACTIONS
3.1	Strong advocacy for the increase in the amount of funds provided to the public health sector to ensure government expenditure on health is 6% of GDP.	Engagement for the mobilize additional resources from new and alternative general revenue sources
		Support the introduction/Establishing of a National Health Insurance Scheme
		Establish systems to improve the collection from patients with private health insurance
3.2	Improved efficiency of how funds provided to the public health sector is allocated and utilized for the delivery of health care services	Establishing a performance based budgetary allocation mechanism in the public health sector;
		Strengthening of MOHW's stewardship of the health sector, oversight, transparency, accountability and interventions to reduce wastage of financial resources;
		Strengthening the systems for financial management, budgeting, auditing, planning, monitoring and evaluation.
3.3	Increased allocation of funds to the first level of care (primary care) to at least 30% of the budget for the public health sector	Incrementally apportioning more of the funds from any new revenue sources to the FLC;
3.4	Consolidate the number of GOJ sponsored public insurance schemes to optimize efficiency	Progressively unifying/pooling all GOJ sponsored public insurance schemes for equity and economies of scale
		Coordinating and harmonizing the benefits and contributions across all GOJ sponsored public insurance scheme
3.5	Introduction of a Package of services/Benefit Package guaranteed to all resident Jamaicans without user fees at the point of service in the public health sector	Package of services defined and approved for delivery within the public health system
		VEN List for Pharmaceuticals are aligned to the service delivery package.
		Supply chain management for all services are aligned with service package to ensure effective and efficient delivery of health care
		Establishing national systems of health intervention and technology assessment, to support cost reduction and the improvement in efficiency and effectiveness within health facilities.

STRATEGIC GOAL 4

ENSURING HUMAN RESOURCES FOR HEALTH SUFFICIENT IN NUMBER AND COMPETENCIES ALIGNED TO THE MODEL OF CARE AND COMMITTED TO THE MISSION

STRATEGIC CONTEXT

The purpose of the Human Resources for Health (HRH) Component of the Vision for Health 2030 Strategic Plan is to facilitate the alignment of the HRH for the Ministry of Health & Wellness with the Initiatives for the decade of 2020-30 and beyond, in keeping with the MOHW Mission: *To ensure the provision of quality health services and to promote healthy lifestyles and environmental practices.*

Health professionals and workers are the backbone of health systems. As such, they are central to the achievement of health outcomes. Without proper attention, however, maintaining equitable distribution of a competent and committed health workforce can become a challenge.

A recent analysis conducted by the Pan American Health Organisation (PAHO) and Dalhousie University classified the challenges in HRH for Jamaica in five areas: i) workforce planning; ii) education and training; iii) deployment and utilization; iv) recruitment and retention and, v) management and leadership.

Increasing demands related to non-communicable diseases (NCDs) and population ageing, combined with financial pressures on health systems, will intensify tensions around the availability, distribution, composition, competencies, management, and performance of human resources for health in Jamaica. Despite improvement in the overall availability of medical doctors, nurses and midwives in recent years, Jamaica continues to struggle with issues of insufficient numbers, deployment and retention of key health providers. Distribution across regions is unequal and equally affects the FLC and hospital care. Loss of nurses and, to a lesser extent, medical doctors and other professionals, through migration is a problem that affects the overall system, triggered by comparatively lower remunerations, career opportunities, and the search for better social conditions abroad. On the other hand, 12% of the current health workforce is 55 years and over, including 1% who are over the age of 65. Based on this information there needs to be greater integration in HRH planning for health services delivery based on population needs considering the potential attrition due to migration, retirement and other causes.

Four crucial outputs must be achieved in order to contribute to the HRH strategic goal:

1. **Appropriate supply of health workers for labour market needs,**
2. **Equitable distribution of health workers,**
3. **Improved health worker performance and**
4. **Effective and coordinated HRH planning, management and development across the health sector.**

Faced with the transformation of the health system, the MOHW is undertaking an extensive review of the established cadre of HRH to ensure necessary adjustments required for alignment to the new model of care and changing health needs. The current cadre and employment arrangements were developed based on realities that are significantly different in this new century. New professional profiles and disciplines and the changing modalities in the training of health professionals, demands changes both by the institutions that train them and those that employ them.

Collaboration and alliances between workers' organizations, professional bodies, training institutions and the MOHW will be key in this transformation. In line with that transformation, this Strategic Plan will undertake to achieve five Strategic Outcomes for HRH.

GOAL 4-STRATEGIC OUTCOMES

	STRATEGIC OUTCOMES	STRATEGIC ACTIONS
4.1	Capacity for National Strategic planning and management of the HRH	Develop a new and comprehensive HRH policy and action plan for the Standard Provisions of the health system
		Establishment of HRH planning mechanism to increase capacity for short- medium- and long-term planning, monitoring and evaluation.
		Strengthen Ministry of Health & Wellness capacity to proactively plan and manage the supply, mix, demand and distribution of health human resources
		Continuously update model projections for national health workforce requirements based on the changing health needs of the country, and aligned with new models of care.
		Develop and implement short, medium and long term plans to improve Jamaica's supply and deployment of health human resources through a combination of recruitment, retention, education, and training strategies and labour market policies.
		Establish a network of key stakeholders in order to establish national health education and training priorities and implement changes.
		Conduct annual process of reviews of existing national, health and HRH policies, identify gaps and revise or develop new policies as necessary
		Foster an organizational culture that supports the implementation of revised policies and systems through leadership of senior management.
4.2	National HRH plan for the public health sector aligned to model of care.	Implement the revised HRH deployment and utilization plan for the public health sector as per the new model of care.
		Reduce rate of migration of clinical staff resulting from implementation of retention policies in the MOHW
		Develop policies for regular, timely sharing of HRH planning data from within and outside MOHW to support planning
4.3	Equitable distribution of health workers across the island based on local needs	Review regulation and enforcement of remote area policies and systems and identify barriers
		Collect, analyse and update distribution data of sanctioned and filled posts disaggregated by location, cadre, gender, and ethnicity.
		Enhance the utilization of population-based metrics to allocate resources across regions by establishing an IT system for planning purposes

STRATEGIC OUTCOMES		STRATEGIC ACTIONS
4.4	Improved Health Worker Performance	Foster a positive labour environment that motivates employees to work efficiently
		Introduction of new human resource categories in the staff cadre in line with changes in the governance schemes, delivery model and the package of services and that facilitate patient safety and improved relations with the clinical staff
		Appointment of a technical team to conclude the preparation of the career development and promotion plan
		Plan Prepare and implement an Employee Climate Survey to update and better understand workers' needs and motivations, especially in the rural area
		Career development and promotion plan completed and first measures implemented
4.5	Training and education programmes that are consistent with the new model of care	Form alliances with public and private institutions that provide educational and training programmes for HRH.
		Prepare an inventory of skills of all clinical and non-clinical staff working under the umbrella of the Ministry of Health & Wellness
		Execute training in Compassionate Care in order to improve the relationships between staff and patients.

STRATEGIC GOAL 5
SOCIAL PARTICIPATION AND HEALTH PROMOTION TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH

CONTEXT

The social determinants of health (SDH) are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The SDH are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.

A crucial direction for policy to promote health equity therefore concerns the participation of civil society and the empowerment of affected communities to become active protagonists in shaping their own health.
The way the health system contributes to social participation and the empowerment of the people, is defined as one of the main axes for the development of the Primary Health Care strategy and in reaching health system goals, such as in the area of responsiveness.

Social participation can take on a number of different forms including:

- **informing people with balanced, objective information;**
- **consulting, whereby the affected community provides feedback;**
- **involving, or working directly with communities;**
- **collaborating by partnering with affected communities in each aspect of the decision including the development of alternatives identification of solutions; and**
- **empowering, by ensuring that communities retain ultimate control over the key decisions that affect their wellbeing.**

Although the MOHW engages the wider community in social participation, primarily through the provision of information, consultations where necessary and working directly with communities on occasion, this process is not systematized and therefore is not consistent and sustainable. In addition, the MOHW would need to aim to actively partner with communities in identifying appropriate solutions to their health issues/concerns.

Civil society participation can strengthen political will around SDH and health education agendas and strengthen people's control over the factors that affect their health - an important social goal. The Ministry of Health & Wellness cannot create participation, but can create spaces that enable and encourage participation. Social participation should seek the empowerment of community groups, increasing their effective control over decisions that influence their health and life quality and their access and use of health services.

The SDH are mostly responsible for health inequities - the unfair and avoidable differences in health status. Intersectoral collaboration and community participation are essential in addressing these determinants and require the consideration of health outcomes in all sectors.

Intersectoral collaboration requires an all-of-government and all-of-society approach to health as a development issue that includes the analysis and consideration of health related goals in the formulation and approval of policies in all sectors of government (i.e. Health in All Policies or HiAP) to address social determinants of health and health inequities in line with the SDG-2030 health agenda.

HiAP is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. As a concept, it reflects the principles of: legitimacy, accountability, transparency and access to information, participation, sustainability, and collaboration across sectors and levels of government.

Health and health equity are values in their own right, and are also important prerequisites for achieving many other societal goals. Many of the determinants of health and health inequities in populations have social, environmental, and economic origins that extend beyond the direct influence of the health sector and health policies. Thus, public policies and decisions made in all sectors and at different levels of governance can have a significant impact on population health and health equity.

The HiAP approach is therefore necessary to protect and promote health and health equity, particularly where there are competing interests. It ensures that health and health equity considerations become part of decision-making.

HiAP provides a means to identify and avoid those unintended impacts of public policy that can be detrimental to the health of populations or subgroups of the population, thus reducing risk.

Rationale

The main risk factors that underlie the majority of the causes of mortality and disability are not entirely within the traditional domain of the MOHW, especially when we examine the underlying social factors which contribute significantly to these health risks. These health risks are related to poor nutritional habits, physical inactivity and other unhealthy lifestyle choices within the framework of the social determinants of health.

The most relevant risk factors in Jamaica can be identified as:

- **Unsafe sex**
- **Dietary risks**
- **Child and maternal malnutrition**
- **Alcohol and drug use**
- **High body-mass index**
- **Low physical activity**
- **Tobacco smoking**
- **Reckless driving**
- **Interpersonal conflicts and lack of emotional intelligence**

There has been insufficient improvement in terms of access to water, electricity and sanitation services, particularly in the rural areas; furthermore, some inner city urban areas are characterised by poor sanitation and drinking water services. These social determinants of health limit the capacity of the country to improve the health conditions of the population affected by non-communicable diseases in particular. Legislation is in place to prevent gender-based violence (GBV), however Jamaica struggles with GBV on par with other countries in the region.

Prevention of work risks and diseases, control of tobacco and alcohol, prevention of traffic accidents, environmental policies (electricity provision, improved water, sanitation and pollution mitigation strategies), prevention of sexual abuse and domestic violence requires an all-of-government approach in order to effectively address these issues which impacts population health outcomes and by extension overall country development.

The environments in which people live, work, learn, and play have a tremendous impact on their health. Responsibility for the social determinants of health falls to many non-traditional health partners, such as housing, transportation, education, air quality, local government, criminal justice, energy, and employment agencies. Public health agencies and organizations will need to work with those who are best positioned to create policies and practices that promote healthy communities and environments and secure the many co-benefits that can be attained through healthy public policy.

GOAL 5-STRATEGIC OUTCOMES

The strategic goals outlined in this ten-year Plan are designed to make a qualitative leap aligned to a concomitant move forward in national development. This achievement requires a whole-of-society commitment. In that respect, the Vision for Health 2030 Plan will focus on:

	STRATEGIC OUTCOMES	STRATEGIC ACTIONS
5.1	Persons and families empowered and engaged in managing their own health	Prioritization of health promotion and education so that individuals and families participate in higher levels of preventative action to take responsibility for their health
		Modernized National Framework for community participation
		Development and implementation of a plan for the promotion of health literacy in communities to empower individuals to make better health choices
		Development and implementation of a comprehensive plan for the promotion of healthy lifestyle programmes in the special settings – schools, communities and workplace, utilizing the 5 pillars of health promotion
5.2	Strengthened health systems through advocacy for the implementation of health in all policies (HiAP) approach across all sectors in government	Development and implementation of a Strategic Framework for Addressing Social Determinants of Health
		Build the capacity of the Ministry of Health & Wellness to engage other sectors of government through leadership, partnership, advocacy and mediation to achieve improved health outcomes.
		Build institutional capacity to support health professionals in acquiring the requisite knowledge and skills around the HiAP approach.

STRATEGIC GOAL 6
MAKING RELIABLE AND MODERN INFRASTRUCTURE AVAILABLE FOR HEALTH SERVICE DELIVERY

RATIONALE

The public health sector has been engaged in a programme of rehabilitation and renewal of its physical infrastructure for several years. Notwithstanding the improvements that have been achieved, much of the health infrastructure, particularly the health centres, remains below acceptable standards. In order to maintain a population in optimal health, the infrastructure must be improved. A well maintained, modern and appropriate infrastructure will help to ensure that delivery of health services is efficient and cost effective. Through this strategy, Vision 2030 Jamaica will improve the infrastructure, including buildings, equipment and systems.

Certainly, the level of infrastructure and equipment needs exceeds by far the financial capacity of the public sector to close the gap with public money. A more intensive role for the private sector through contracting-out and Public-Private Partnerships seems to be a possible response. The Ministry of Health & Wellness should identify areas of service excess demand, on one hand, and availability of existing private providers on the other, to evaluate where contracting private would be an appropriate response to ensure quick access to limited services, like mammography.

In the case of infrastructure, PPPs can be an alternative to build and operate several projects simultaneously. In this case, the MOHW should reinforce its institutional capacity to detect options, organize bidding processes and execute projects of this nature on a massive scale.

OPTIONS FOR PRIVATE SECTOR PARTICIPATION IN HOSPITALS

OPTIONS	PRIVATE SECTOR RESPONSIBILITY
Outsourcing nonclinical support services	Provides nonclinical services (cleaning, catering, laundry, security, building maintenance) and employs staff for these services.
Outsourcing clinical support services	Provides clinical support services such as radiology and laboratory services.
Outsourcing specialized clinical services	Provides specialized clinical services (such as lithotripsy) or routine procedures (cataract removal)
Private management of public hospital	Manages public hospital under contract with government or public insurance fund and provides clinical and nonclinical services. May employ all staff and be responsible for new capital investment, depending on the terms of the contract.
Private financing, construction and leaseback on new public hospital	Finances, constructs, and owns new public hospital and leases it back to government.
Private financing, construction and operation of new public hospital	Finances, constructs, and operates new public hospital and provides nonclinical or clinical services or both.

PAHO/WHO Smart Hospitals Initiative aims to provide a platform for integrating Disaster Risk Reduction, Climate Change Adaptation and Conservation Efforts to provide safer, green health facilities to deliver care in disasters.

Through adoption of the tools and approaches of the project, the Ministry will seek to develop resilient and climate adapted health care facilities through the application of interventions aimed at reducing the vulnerability of the facilities and their impact on the environment.

The following tools developed will be utilised:

- **Hospital Safety Index (HSI);**
- **Baseline Assessment Tools (BAT) (which takes into consideration age, physical condition, quality of construction, structural and non-structural and mechanical integrity and compliance with appropriate building codes);**
- **Green Checklist (a low cost adaptation measure using adapted green rating systems for the Caribbean)**
- **Cost Benefit Analysis Tool to be used in Selecting facilities for Retrofitting; and**
- **A web-based Smart App that allows information that may inform improvement works. As requested, the link to the Smart App is "smarthospitals.info/smart/index.php." This App is still undergoing testing and improvements.**

A combination of the HSI and Green Checklist provides a rating for the facility. A rating of A70 is considered satisfactory. The BAT was applied to eight facilities in Jamaica - seven Health Centres (Types 3 and 4) and one 40 bed Specialist Hospital and took 23 components into consideration for retrofit improvement works. Cost Estimates for these works ranged from US$45 - 107 per square foot. The variation in estimates reflects the degree of works required to bring the facility to A70 standard.

As mentioned previously, the proposed revised primary care service delivery system will consist of three main categories of Health Centres replaces the existing 5 categories with three categories:

The three revised primary care institutions will be the following:

- Community Health Centres
- District Health Centres
- Comprehensive Health Centres

Proposed revision of the primary care infrastructure will be informed by the standards related to the three tiers, allowing the reformed health system effectively deliver the Essential Package of Health Services.

Procurement of medical equipment will be centralized to ensure standardization of the equipment applied in all related entities across the health care sector. A full-scaled standardization of the equipment will reduce maintenance cost significantly as compared to the present situation where equipment is of various brands and standards. In accordance with the proposed Procurement Plan MOHW should adopt a procurement policy for the standardization of the equipment including development of a related Maintenance Plan aiming to standardize equipment and utilities throughout the public health system.

In particular, this policy should be oriented at procurement of IT and medical high-tech equipment to allow efficiency in function, maintenance and replacements throughout the system. The Procurement & Maintenance Plan needs to be in place in the first year of the 10-year Plan in order to specify the equipment need related to the Implementation Plan.

GOAL 6-STRATEGIC OUTCOMES

	STRATEGIC OUTCOMES	STRATEGIC ACTIONS
6.1	Establish standards for construction and maintenance of health facilities in keeping with international best practices and ensure that they are observed.	Develop standards for secondary care facilities in keeping with international best practice. Develop standards for resilient and climate adapted facilities through the application of interventions aimed at reducing the vulnerability of the facilities and their impact on the environment
6.2	Provide and Maintain an Adequate Health Infrastructure to Ensure Efficient and Cost Effective Service Delivery	Advocating for the fiscal space for capital investment in order to retool the public health sector Rehabilitating Critical Health Infrastructure o Dedicate more resources to operations and maintenance of health facilities o Identify resource gap and potential sources of funding for operations and maintenance of health infrastructure o Integrate specific training on maintenance and/or maintenance plans into contracts for critical health infrastructure o Review/strengthen/modify the levels of responsibility and authority within the MOHW for the effective management of medical equipment. o Provide the overarching framework for the development of operating/preventive maintenance/replacement procedures, which, when implemented, will ensure that the established equipment performance standards are consistently achieved. o Review and modify/ strengthen the existing mechanisms for monitoring and reporting on the performance of medical equipment, including the mechanisms to ensure accountability by those charged with the responsibility for managing medical equipment.

IMPLEMENTATION, MONITORING AND EVALUATION

This Vision for Health 2030 Plan will be implemented through the various initiatives that are outlined in the organization's Strategic Business Plan and the different programmatic plans. In going forward, the revision of the Strategic Business Plans and various initiatives will be conducted as to ensure full alignment with the Vision and national targets of this Vision for Health 2030 Plan.

Implementation will be a collaborative effort between the Ministry of Health & Wellness and other sectors towards the achievement of goals and outcomes delineated in the Vision 2030 Jamaica. Monitoring, assessment, and reporting is an integral part of the evaluation framework of the health system. In keeping the MOHW's commitment to improving accountability and transparency, the overall performance of the Vision for Health 2030 Plan will be assessed using outcome and impact indicators related to each strategic outcome.

A compendium of indicators that provides standard definitions and measurement criteria for all indicators, will be developed in order to standardize monitoring and reporting of progress toward the achievement of the indicators' targets.

The reporting mechanisms will include quarterly meetings in which RHAs present progress reports and assessments on the achievements. A commitment from all programme areas to report on progress toward achievement of the indicators will be required in order to effectively monitor the implementation of the Vision for Health 2030 Plan. The Jamaica Accountability Framework will guide reporting of this Vision for Health 2030 Plan in the context of monitoring and assessing national development programmes and providing transparent and accountable reporting.

Service Level Agreement

It is proposed that the process to establish Service Level Agreements (SLA) between the MOHW and the RHA be revised to improve accountability and performance. The objective of the revised SLA process is to have the MOHW specify targets for healthcare goals, in accordance with national policy objectives, to be attained by each RHA. The RHA is then required to breakdown these targets and establish performance goals for each facility under its jurisdiction - health centres, hospitals etc. The revised SLA requires the RHA to report on the aggregate of its facility goals and to indicate how many facilities are not meeting the national target and the actions being taken for them to meet the required target. When reporting on its performance under the SLA, the RHA is also required to make available data on the performance of each facility to the Monitoring & Evaluation section of the MOHW.

The revised SLA process is expected to improve performance management and sharpen the focus on service delivery starting with the delineation of targets stemming from the MOHW supported by the measurement of performance for each facility. Improved resource utilisation comes through the redefinition and refocusing of the organisational structure with increased emphasis and accountability on the delivery of services by the personnel directly involved.

ANNEXES

ANNEX 1: BASIC PACKAGE OF HEALTH SERVICES BY PRIMARY, SECONDARY AND TERTIARY CARE

DEFINITIONS

Primary Care: health care provided by a medical professional (such as a general practitioner, pediatrician, or nurse) with whom a patient has initial contact and by whom the patient may be referred to a specialist

Secondary Care: medical care that is provided by a specialist or facility upon referral by a primary care physician and that requires more specialized knowledge, skill, or equipment than the primary care physician can provide

Tertiary Care: highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities

Primary Care	Secondary &Tertiary Care
CHILDHOOD	
Preventive and wellness services Well Child (comprehensive health and development) services Complete vaccination according to country regulations and guidelines Care of the newborn Control of growth and development from birth to 13 years Integral (child and family) treatment in case of malnutrition and iron deficiency Prevention and treatment of epidemics Care of acute respiratory infections and asthma Acute diarrheal disease treatment and care Anti-parasite treatment Oral & dental chronic disease management	Medical services Comprehensive newborn care and screening (for select diseases and disabilities) Preventive & Restorative Dental services Vision & Hearing Screening and Referral of school-aged child Eyeglasses Rehabilitative services and devices Laboratory services Ophthalmology and Optometry Referral services Specialist care Neonatal emergency care Paediatric general and specialist surgery Ophthalmology and Optometry Ambulatory (Day) Surgery Hearing Aids *Targeted Lead Toxicity Screening services Health Services for children with disabilities Cleft Palate
PREGNANT WOMEN	
Comprehensive control of pregnancy and its complications Birth care and its complications Postpartum care and family planning Promotion of breastfeeding HIV + mother's care Impregnated mosquito nets Ambulatory patient services	Maternity (delivery) services and complications Postnatal services PMTCT services and DNA-PCR Testing Obstetrics and Gynaecology routine treatment protocols Obstetrics and Gynaecology surgery Depression screening
ADOLESCENT POPULATION	
Sexual and reproductive health services Prevention of sexual abuse and violence Healthy Eating to Prevent Overweight and Obesity Prevention of alcohol, tobacco and other drug use Promotion of mental health Detection and treatment of tuberculosis Asthma detection and treatment Prevention and treatment of malaria	Reproductive health services Mental health Substance use disorder services Prescription drugs Oral and restorative care Tertiary care and hospitalization based on recommendations from secondary caregivers
ADULT POPULATION	
Physical (Preventive Health Maintenance) Examination NCD Risk Assessment Cancer Screening services (for all priority cancers) Detection and treatment of hypertension and diabetes Cardiovascular risk education, prevention and healthy eating Chronic Kidney Disease	Chronic disease management HIV Counselling & Testing Physician/Clinic Visit Diagnostic testing – *Radiology, Electrocardiography* Orthopaedic services Out-patient surgery (*e.g. sterilization*) Out-patient treatment therapies (chemotherapy, radiotherapy, non-preventive infusion and IV therapy) STI Clinic services & Contact Investigation

ANNEX 2: PROPOSED PRIMARY HEALTH CARE STRUCTURE

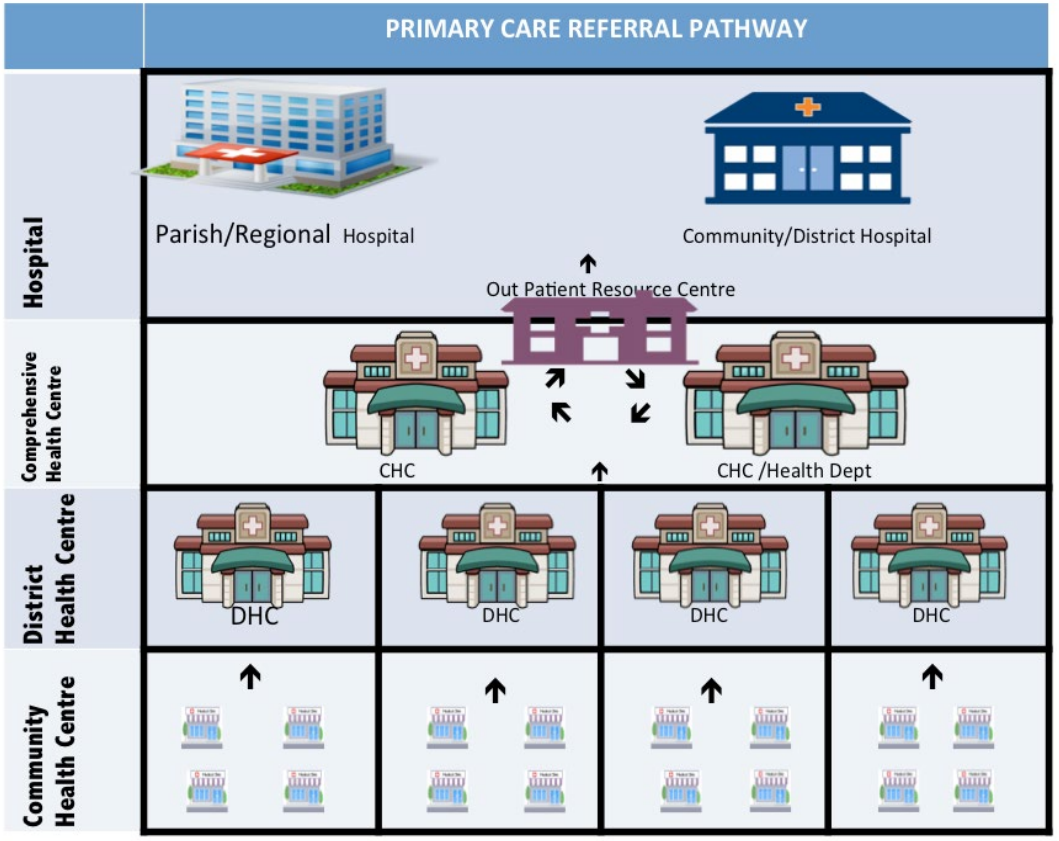
THE COMMUNITY HEALTH CENTRE

The community health centre serves a population of up to 20,000 depending on location. This health centre will serve combined communities previously served by Type 1 or Type 2 health centres with increased staff and services. The range of services has been expanded due to the changing demands that have arisen out of the change in demographics and epidemiology. While it remains important to provide maternal and child health services, the rise in Non communicable diseases in particular hypertension, diabetes, cancers and trauma has resulted in an increase in persons seeking a higher level of care in hospitals and where not accessible, this has resulted in delays to care with worsening outcomes. The solution is to bring a higher level of care to the first level of care in the community health centre. The community health centre therefore now has expanded services and a higher level of staff to provide this care . Infrastructure changes will also support this.

The Community Health Centre will provide core services such as Curative services, Maternal and Child Health services, Wound care on a daily basis while some services such as Nutrition and Mental Health Clinics will be offered regularly but less frequently. Maternal and Child Health Clinics and Treatment (Curative) Clinics are held daily. Walk ins and appointments are seen. Walk-ins are triaged and seen based on priority level. At each interaction, regardless of presenting complaint, the stage in the life course is considered and patient education and management is offered. Priority screening services, specialist referrals and diagnostic and therapeutic services are to be offered/ scheduled and the patient directed to the facility where the service is to be obtained.

Difficult cases or cases requiring Specialist attention are referred to the Specialist Clinics at the District or Comprehensive Health Centres for a management plan to be crafted and the opportunity for discussion is provided to the Health care provider. This service will not only provides a higher level of service but also is a means of ensuring continued medical education and mentoring for health professionals.

Outreach programmes are to be carried out in the communities served by the Community Health Centre by the Community Health Aides, Public Health Nurses and Physicians stationed there. The outreach programmes are organized from the level of the Community Health Centre and the District Health Centre that oversees the Community Health Centre.



THE DISTRICT HEALTH CENTRE

The District Health Centre offers the next tier of service. This health centre will provide the same services as the Community Health Centre (CHC) but will also provide a higher level and range of services for a population of up to 40,000 persons from the communities served by its feeding CHCs. The number served will vary from parish to parish. In the more populated parishes of St. Catherine and Kingston & St. Andrew some DHCs will serve up to 80,000 persons.

The DHC will have visiting clinical specialists. The specialist service provided will be dependent on demographics and epidemiology of the area served and will be decided by the Ministry of Health in conjunction with the RHA. Patients can be referred from the CHC for specialist care as well as for other services not provided at CHC. The package of services at the DHC is focused on providing both preventative and curative health services as well as core public health services such as Environmental Health.

The full package of services to be offered at each DHC is influenced by the proximity of a Comprehensive Health Centre and/or a Hospital and the population of the district served.

Maternal and Child Health Clinics, Treatment (Curative) Clinics and Dental Clinics are held daily. Walk ins and appointments are seen. Walk-ins are triaged and seen based on priority level. At each interaction, regardless of presenting complaint, the stage in the life course is considered and patient education and management is offered. Priority screening services, specialist referrals and diagnostic and therapeutic services are to be offered/scheduled and the patient directed to the facility where the service is to be obtained. Clinics for Specialist services are scheduled and walk-ins and referrals are seen on an appointment basis.

Difficult cases are referred to the Specialist for a management plan to be crafted and the opportunity for discussion is provided to the Health care provider on site on acute or chronic cases. This service will not only provide a higher level of service but also be a means of ensuring continued medical education and mentoring for health professionals.

Cases referred from the Community Health Centres and Community Outreach programmes are seen and feedback provided to the referring facility. Documentation of services provided and recommendations as a result of a referral should be made for patients returning to the Health Centre after being referred to other facilities.

THE COMPREHENSIVE HEALTH CENTRE

The Comprehensive Health Centre is the major referral centre for primary care services. Specialist services and programmes for continued medical education will be offered through a combination of specialist run clinics and telemedicine. The development of Health Information Systems and Internet and Intranet connectivity will allow for communication and feedback at all levels of the health system. More diagnostic and therapeutic services will be available on site and off site through real and virtual integration. Special services such as Social Work, Rehabilitative and Palliative services will be introduced to address the increased need. Access to therapeutic services such as Dialysis and Oncology services are to be explored in an effort to increase accessibility and compliance with treatment. In some regions a main out patient resource centre, with access to diagnostics by primary care patients will be a part of the network, although this may not be present at the location of the Comprehensive Health Centre.

The Comprehensive Health Centre will provide the range of services as the District Health Centre as well as additional specialist and diagnostic services. Specialists engaged in Primary Care and Secondary Care will provide services at the Comprehensive Health Centre and Out Patient Resource Centre.

Out Patient Resource Centre

The Out Patient Resource Centre is a major addition to the primary care network that will facilitate the integration of services and increase access to what was previously considered hospital services. The Centre will be located in close proximity to the Parish hospital and the Comprehensive Health Centre. This facility will house specialist clinics, diagnostic services and therapeutic services. Staff from the hospital will provide services in their dedicated time for primary care. This centre will be a hub for technology driven continued medical education through tele-consulting and tele-conferencing.

GLOSSARY

Clinical Integration: The extent to which patient care is coordinated across the system's different functions, activities and operating units. The degree of coordination of care depends primarily on the patient's condition and the decisions made by his or her health team. Clinical integration includes horizontal and vertical integration (Modified from Shortell SM; Anderson DA; Gillies RR; Mitchell JB; Morgan KL. Building Integrated Systems: The Holographic Organization. Healthcare Forum Journal 1993; 36(2):20-6).

Comprehensive, Integrated, and Continuous Health Services: The management and delivery of health services such that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, through the different levels and sites of care within the health system, and according to their needs throughout the life course (Modified from WHO. Integrated Health Services–What and Why? Technical Brief No. 1, May 2008).

Coverage: The capacity of the health system to serve the needs of the population, including the availability of infrastructure, human resources, health technologies (including medicines) and financing.

Continuity of Care: The degree to which a series of discrete health care events is experienced by people as coherent and interconnected over time, and consistent with their health needs and preferences (Modified from Haggerty JL, Reid RJ, Freeman GK, Starfield B, Adair CE, McKendry R. Continuity of Care: A Multidisciplinary Review. BMJ 2003; 327(7425):1219–1221).

Determinants of Health: The determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources and have origins that extend beyond the direct influence of the health sector and health policies.

Equity in Health: Absence of unfair differences in health status, access to healthcare and health-enhancing environments, and treatment within the health and social services system (PAHO. Renewing Primary Health Care in the Americas: A Position Paper of the Pan American Health Organization/World Health Organization (PAHO/WHO). Washington, D.C., 2007).

First Level of Care: In this document, preference has been given to the term "first level of care" instead of the term "primary care" in order to avoid confusion with the concept of Primary Health Care (PHC). For PAHO, PHC represents a broad approach to the organization and operation of the health system as a whole, and not only the delivery of health services at the first level of care. The term primary care, like the first level of care, has been defined by the USA's Institute of Medicine as the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community (Institute of Medicine. Primary care: America's Health in a New Era. Washington, D.C.: National Academy Press, 1996).

Health System: All organizations, people, and actions whose primary intent is to promote, restore or maintain health (Modified from WHO. The World Health Report 2000: Health Systems: Improving Performance. Geneva, 2000).

Integrated Health Service Delivery Network: A network of organizations that provides, or makes arrangements to provide, equitable, comprehensive, integrated, and continuous health services to a defined population and is willing to be held accountable for its clinical and economic outcomes and for the health status of the population served. (Modified from Shortell, SM; Anderson DA; Gillies, RR; Mitchell JB; Morgan KL. Building Integrated Systems: The Holographic Organization. Healthcare Forum Journal 1993; 36(2):20–6).

Life Course: An approach based on a model that suggests that the health outcomes of individuals and the community depend on the interaction of multiple protective and risk factors throughout people's lives. As a result, each stage of life influences the next. The factors refer to environmental, biological, behavioral, and psychological characteristics and access to health services. This approach provides a more comprehensive vision of health and its determinants, which calls for the development of health services more centered on the needs of its users in each stage of their lives (Modified from Lu M, Halfon N. Racial and Ethnic Disparities in Birth Outcomes: A Life-Course Perspective. Mat and Chil Health J 2003; Vol 7, No. 1:13-30).

PHC-Based Health System: An overarching approach to the organization and operation of health systems that makes the right to the highest attainable level of health its main goal while maximizing equity and solidarity. A PHC-based health system is composed of a core set of functional and structural elements that guarantee universal coverage and access to services that are acceptable to the population and that are equity-enhancing. It provides comprehensive, integrated and appropriate care over time emphasizes health promotion and prevention and assures first contact care. Families and communities are its basis for planning and action. A PHC-based health system requires a sound legal, institutional and organizational foundation as well as adequate and sustainable human, financial and technological resources. It employs optimal organization and management practices at all levels to achieve quality, efficiency and effectiveness and develops active mechanisms to maximize individual and collective participation in health. A PHC-based health system develops intersectoral actions to address determinants of health and equity (PAHO. Renewing Primary Health Care in the Americas: A Position Paper of the Pan American Health Organization/World Health Organization (PAHO/WHO). Washington, D.C., 2007).

Public Health: An organized effort by society, primarily through its public institutions, to improve, promote, protect and restore the health of the population through collective action. It includes services such as health situation analysis, health surveillance, health promotion, prevention, infectious disease control, environmental protection and sanitation, disaster and health emergency preparedness and response, and occupational health, among others (PAHO. Public Health in the Americas: Conceptual Renewal, Performance Assessment and Bases for Action. Scientific and Technical Publication No. 589. Washington, D.C.: OPS; 2002).

Public Health Services: Health services targeted at the population as a whole. These include, among others, health situation analysis, health surveillance, health promotion, prevention services, infectious disease control, environmental protection and sanitation, disaster preparedness and response, and occupational health (PAHO. Public Health in the Americas: Conceptual Renewal, Performance Assessment and Bases for Action. Scientific and Technical. Publication No. 589. Washington, D.C., 2002).

Segmentation (of health systems): The coexistence of subsystems with different modalities of financing, affiliation and health care delivery, each of them 'specializing' in different strata of the population according to their type of employment, income level, ability to pay, and social status. This kind of institutional arrangement consolidates and deepens inequity in access to health care services across different population groups. In organizational terms, segmentation is the coexistence of one or more public entities (depending on the degree of decentralization or deconcentration), social security (represented by one or more entities), different financers/insurers, and private providers (depending on the extent of market and business management mechanisms introduced during sectoral reforms) (PAHO. Health in the Americas 2007. Vol. I, p. 319, Washington, DC: PAHO; 2007).

Universal access: the absence of geographical, economic, sociocultural, organizational, or gender barriers. Universal access is achieved through the progressive elimination of barriers that prevent all people from having equitable use of comprehensive health services determined at the national level.

Universal health coverage: implies that the organizational mechanisms and financing are sufficient to cover the entire population. Universal coverage is not in itself sufficient to ensure health, well-being, and equity in health, but it lays the necessary groundwork (2).

Universal access to health and universal health coverage (Universal Health): imply that all people and communities have access, without any kind of discrimination, to comprehensive, appropriate and timely, quality health services determined at the national level according to needs, as well as access to safe, effective, and affordable quality medicines, while ensuring that the use of such services does not expose users to financial difficulties, especially groups in conditions of vulnerability. Universal access to health and universal health coverage require determining and implementing policies and actions with a multisectoral approach to address the social determinants of health and promote a society-wide commitment to fostering health and well-being.

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