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**UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
Washington, D. C. 20523**

JAMAICA

PROJECT PAPER

HEALTH SECTOR INITIATIVES

AID/LAC/P-481

Project Number: 532-0152

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AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE **A** A = Add
C = Change
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Amendment Number _____ DOCUMENT CODE **3**

2. COUNTRY/ENTITY **JAMAICA**

3. PROJECT NUMBER **532-0152**

4. BUREAU/OFFICE **LAC** **05**

5. PROJECT TITLE (maximum 40 characters) **Health Sector Initiatives Project**

6. PROJECT ASSISTANCE COMPLETION DATE (FACD) MM DD YY **07 15 96**

7. ESTIMATED DATE OF OBLIGATION (Under "B" below, enter 1, 2, 3, or 4)
A. Initial FY **89** B. Quarter **4** C. Final FY **95**

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	200	268	468	1,754	3,246	5,000
(Grant)	(200)	(268)	(468)	(1,754)	(3,246)	(5,000)
(Loan)	()	()	()	()	()	()
Other U.S. 1.						
2.						
Host Country						
Other Donor(s)					1,855	1,855
TOTALS	200	268	468	1,754	5,101	6,855

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) HE	580	520	-			5,000		5,000	
(2) -	-	-	-						
(3) -	-	-	-						
(4) -	-	-	-						
TOTALS						5,000		5,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each) **530**

11. SECONDARY PURPOSE CODE **500**

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)
A. Code **BR** **BUW**
B. Amount

13. PROJECT PURPOSE (maximum 480 characters)
To improve the quality and efficiency of current and future health services delivery.

14. SCHEDULED EVALUATIONS
Interim MM YY **05 93** Final MM YY **01 96**

15. SOURCE/ORIGIN OF GOODS AND SERVICES
 000 941 Local Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment)
USAID/Jamaica Controller has reviewed and concurs with the methods of implementation and financing included herein.

Signature **Robert A. Leonard**

17. APPROVED BY
Mvron Golden
Acting Director
USAID/Jamaica
Date Signed **MM DD YY 10.7.96**

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM DD YY

Table of Contents

	Page
Acronyms	1
List of Project Design Team	11
I. SUMMARY PROJECT DESCRIPTION	1
A. Summary of the Problem	1
B. Summary of the Project	1
II. PROJECT BACKGROUND AND RATIONALE	2
A. Scope of the Problem	2
1. Health status in Jamaica	2
2. Status of Health Care System and Its Financing	4
B. Project Rationale and Strategy	5
C. Project Relationship to GOJ Development Plans and to USAID Strategy	7
1. GOJ Health Sector Strategy	7
2. GOJ Policy and Actions in Health Care Financing	7
3. USAID CDSS and Health Sector Strategy	8
D. Relationship To Other Donor Programs	9
III. PROJECT DESCRIPTION	9
A. Project Goal and Purpose	9
B. Project Accomplishments	10
C. Project Outline and How It Will Work	12
1. Public Sector - Financing	13
a. Policy Framework	13
b. More Efficient Cost Recovery Through User Fee Reforms	15
c. Social Marketing	16
2. Public Sector - Management	18
a. Headquarters Strengthening	18
b. Alternative Management of Public Facilities	19
c. Primary Care	20
d. Secondary Care	21
3. Private Sector	22
a. Investment Climate Study	22
b. Private Sector Technical Support	23
4. Project Implementation and Administration	4
5. Annualized Project Outputs	5

Table of Contents (cont'd)

	Page
IV. Cost Estimates and Financial Plan	26
A. Summary Cost Estimate and Financial Plan	26
B. Costing of Project Outputs/Inputs	26
C. Projection of Expenditures by Fiscal Year	26
D. Methods of Implementation and Financing	26
V. Implementation Plan	31
A. Project Management Responsibilities and Organization	31
B. Procurement Plan	32
C. Project Monitoring and Evaluation	33
D. Implementation Schedule	34
VI. Summaries of Analyses	35
A. Technical Analysis	35
B. Institutional and Administrative Analysis	43
C. Social Soundness Analysis	44
D. Economic and Financial Analysis	46
E. Environmental Analysis	48
VII. Conditions & Covenants	48
ANNEXES	
ANNEX A. Logical Framework Matrix	
ANNEX B. PID Approval Cable	
ANNEX C. Statutory Checklist	
ANNEX D.1. Technical Analysis - Public Sector	
ANNEX D.2. Technical Analysis - Health Insurance Industry	
ANNEX D.3. Technical Analysis - Private Sector	
ANNEX E. Institutional and Administrative Analysis	
ANNEX F. Social Soundness Analysis	
ANNEX G. Economic and Financial Analysis	
ANNEX H. Environmental Threshold Decision	
ANNEX I. Letter of Request from the GOJ	
ANNEX J. Letter from MOH on Hospital User Fee Policy	

List of Acronyms

ALICO	American Life Insurance Company
EEC	Europe Economic Community
GDP	Gross Domestic Product
GNP	Gross National Product
GOJ	Government of Jamaica
HMIP	Health Management Improvement Project
HMO	Health Maintenance Organization
IDB	Inter-American Development Bank
IQC	Indefinite Quantity Contracts
IRM	Information Resources Management
JAMPRO	Jamaica Promotions, Limited
KAP	Knowledge, Attitude and Practices
LSMS	Living Standard Measurement Survey
MOH	Ministry of Health
PAHO	Pan American Health Organization
PAMCO	Project Analysis and Monitoring Company Ltd.
PHC	Primary Health Care
PID	Project Identification Document
PIU	Project Implementation Unit
PNP	Peoples National Party
PPO	Paid Provider Organization
PRICOR	Primary Health Care Operations Research
PSOJ	Private Sector Organization of Jamaica
RFP	Request for Proposal
RFTP	Request for Technical Proposal
STDs	Sexually Transmitted Diseases
TLs	Tubal Ligations
UWI	University of the West Indies
VJH	Victoria Jubilee Hospital

Project Design Team

This Project Paper was developed by the following USAID/Jamaica staff:

Rebecca W. Cohn, Director, Office of Health, Nutrition and Population
Beth E. Cypser, Project Development Officer
Patricia J. Lerner, Chief, Project Development and Support Division
Paul Crowe, Director, Office of Program and Economic Planning
Joy Jones, Program Specialist, Office of Health, Nutrition and Population
Mathias Gweshe, Financial Management Officer

With the short-term consultancies of:

Robert G. Pratt, International Science and Technology Institute, Inc.
Maureen Lewis, Urban Institute
James G. Barnes, Health Systems Marketing and Development Corporation
Trevor Hamilton and Associates

* * * * *

The Project Paper was reviewed by:

William R. Joslin, Director, USAID/Jamaica
Myron Golden, Deputy Director, USAID/Jamaica
Robert Leonard, Controller
Walter Coles, Chief, Private Sector Office

I. SUMMARY PROJECT DESCRIPTION

A. Summary of the Problem

The public health sector in Jamaica is funded almost entirely out of general operating revenues through the Consolidated Fund and, for the five year period 1981/82 through 1985/86, government spending on health care, in terms of constant dollars has declined. In spite of this decline, the government's twenty-four hospitals continue to provide ninety-nine percent of the island's inpatient care. Additionally, public facilities serve nearly all of the island's lower income groups. As a result of this high volume and reduced real funding, the system is showing signs of stress. Facilities are in disrepair; equipment is frequently "down"; and, poor working conditions and inadequate pay have made it difficult for the public sector to attract and retain staff. Additionally, the total reliance on the Consolidated Fund for funding provides few incentives for managers or physicians to institute cost-effective practices. The absence of island based health care management training programs and the resulting shortage in trained administrators has exacerbated the system's management problems.

Private health insurance reaches only a small fraction of its estimated potential market with coverage currently reaching fifteen percent of the population. Impediments to further growth include a lack of consumer education about the advantages of private insurance; difficulty marketing insurance to informal sectors of the economy; and importantly, the availability of "free" government funded health care.

The private health care sector has excess capacity and few service users. The system is funded through individual payments for services and through private health insurance. However, as noted above, private health insurance is not widely used on the island, paying for health services is beyond the reach of most Jamaicans, and the MOH does not pay for health care services rendered in the private sector. Services utilization is low and many private sector providers are reporting financial difficulties. The private sector's problems are compounded by public sector policies such as high interest rates and duty taxes that make it difficult to purchase equipment and raise capital. These problems have combined to hamper growth in the private sector.

Although traditionally, the public sector has been the main provider of health services on the island, it is, however, becoming increasingly apparent that in order to maintain services and an acceptable level of care, public facilities must seek support from and begin to work with private providers and financiers, while at the same time improvements are made in the efficiency and quality of publicly provided health care services.

B. Summary of the Project

The Project will address the problem of insufficient public resources to provide free health services for all citizens, regardless of income. The objectives are:

- to spread the financial burden of health care costs by tapping additional resources; and

-- to improve the quality of health care services.

Over the seven year life of the Project, the Project will assist the Ministry of Health (MOH) in the areas of financing and management, specifically: to analyze and formulate long term policy options for sustainable mechanisms to finance health care in Jamaica; increase cost recovery through improved systems of user fees; and improve the quality of health care services through improved management and planning structures and rationalized health care services in both primary and secondary care.

The Project will improve cost efficiency in public facilities through improved management and rationalization of staff and facilities, and the privatization of support services. Efficiency activities will concentrate on strengthened management in primary and secondary care, headquarters, and alternative approaches to managing public facilities.

The Project will work simultaneously with the public and private health sectors in the areas of health services utilization, drug costs and utilization, health insurance coverage and adoption of public sector policies to facilitate increased health insurance coverage and private sector expansion. The Project will promote the shifting of financial and health care delivery burdens to the private sector for those who can afford to pay. This shift will be promoted by more efficient cost recovery, increased health insurance coverage, and social marketing to promote these efforts.

Expected outputs are increased levels of health insurance coverage, increased private sector investments in health care, improved quality of care, improved financial viability of the private health sector and strengthened public and private partnerships in health. A summary budget follows:

	<u>USAID</u>	<u>GOJ</u>	<u>TOTAL</u>
1.a. Policy Framework	415	--	415
1.b. More Efficient Cost Recovery	259	--	259
1.c. Social Marketing	385	--	385
2.a. Headquarters Strengthening	236	256	492
2.b. Alternative Management	638	182	820
2.c. Primary Care	126	--	126
2.d. Secondary Care	684	482	1166
3.a. Investment Climate Study	25	--	25
3.b. Private Sector Technical Support	550	--	550
4.a. MOH - PIU	752	935	1687
4.b. Private Sector Implementation	246	--	246
Audit & Evaluation	229	--	229
Contingency & Inflation	<u>455</u>	<u>--</u>	<u>455</u>
TOTAL	5,000	1,855	6,855

II. PROJECT BACKGROUND AND RATIONALE

A. Scope of the Problem

1. Health Status in Jamaica - Health status in Jamaica is among the best in the developing world, with an official infant mortality rate in 1984 of

13.2/1000 live births, and life expectancy of 70 years. Along with improvements in health status measures over the past few decades has come a shift in disease incidence toward chronic diseases of adults such as diabetes and heart disease. Thus, as health problems evolve toward the developed country patterns, the health system is meant to address both the historically important infant and childhood illnesses and emerging adult health problems through the preventive primary health care network as well as the hospital system. This has led to a broad and all encompassing set of services that includes home visits, pre- and postnatal care, and dental care, among other services, in addition to the full range of curative care services. Jamaica's vital statistics for certain years between 1980 and 1986 indicate how well the country is managing its health, and the trend is toward further improvement. Crude death rates and the infant mortality rate approach levels for developed countries. Although the crude birth rate is high, once the adjustment is made for age distribution, which is strongly biased toward the childbearing ages of 14 to 49 due to earlier high fertility, the measures are low by developing country standards. Indeed, total fertility is 3, down from 5.5 in 1970 and below the 4.8 1984 average for lower middle income countries (World Bank, 1986).

The only area where progress has lagged is in maternal mortality. In 1982 the maternal mortality rate was roughly forty times that of a developed country average (Samuels, 1987). Maternal deaths are concentrated among women over age 34, which suggests a link to fertility at older ages.

The sources of Jamaican mortality also parallel those of the developed world at least for the main causes based on the leading causes of death for 1979 and 1981. For the most part, the rankings are roughly the same for the two years. The rate has declined for the lower ranked causes and has risen slightly for three of the four major killers, cerebrovascular disease, heart disease, and hypertensive disease. Morbidity measures offer additional detail on the frequency of health problems. After normal deliveries, accidents, poisoning and violence show the highest rates for hospital admittance based on 1983 data (Swezy et al., 1987). At the health center level, hypertension and leg ulcers account for the largest proportion of curative visits.

Thus, the disease pattern underlying mortality and morbidity in Jamaica is heavily biased toward chronic diseases and accident-related problems, not unlike developed countries. The exceptions are the high maternal mortality rate, and the relatively high incidence of gastroenteritis and sexually transmitted diseases (Swezy et al., 1987), and are largely treated at outpatient facilities.

The implications of Jamaica's disease pattern is that the health system must provide and finance both simple prevention and treatment interventions for mothers and children as well as sophisticated tracking, prevention and treatment for adults who are plagued by chronic diseases that are costly to treat because of their long term nature and often times by the expense of the technologies used to treat them (eg. radiation, chemotherapy, dialysis). The transition from communicable to chronic disease predominance in Jamaica is in effect contributing to the problem of underfinancing because the breadth and costs of treatment are expanding, placing additional pressure on public sector resources.

2. Status of Health Care System and Its Financing - Health care services are provided free or at nominal charge to all citizens. Services range from a broad primary health care network to sophisticated tertiary care, and all Jamaicans have relatively easy access to all levels of health care services (McFarlane and McFarlane, 1987).

The comprehensive nature of subsidized care and the expansion of primary health care in recent years, combined with severe macroeconomic difficulties, has taken a toll on the quality of health care, however. Negative economic growth over the past decade, average annual inflation of 16.6 percent and a rapidly climbing debt service prompted government to curtail spending early in the decade. The health sector received modest increments in its nominal budget over the 1980s, and its proportion of the recurrent budget increased. The sector's share of the capital budget, however, almost disappeared, to 5-10 percent of total health expenditure during the period 1980-1984 (Abel-Smith, 1987). Despite some nominal increments, the real value of total resources available for health was seriously eroded between 1980 and 1987. Moreover, devaluation, which raised the cost of imported medical supplies and pharmaceuticals, further reduced the spending power of domestic resources on non-labor items.

Deficiencies in financing of recurrent costs are evidenced by:

- delays in paying bills;
- accumulated arrears in the maintenance of buildings;
- extent to which equipment is awaiting repair or replacement;
- irregular supply of drugs - particularly at health centers;
- unacceptable waiting time for inpatient care accompanied by low occupancy in other than Type A hospitals; and
- unfilled vacancies for nurses, doctors, anesthetists and others (Abel-Smith, 1987).

Government hospitals are financed almost exclusively by tax revenues with only modest amounts generated from recently introduced user charges (Lewis, 1989). Hospitals have been receiving an increasingly smaller portion of the already constrained health budget due to the expansion of the primary health care system. Within hospital budgets, 70 percent goes to personal emoluments, only a fraction of which (10-15 percent) pays physicians. Per patient budget allocations by hospital, adjusting for case mix across public, quasi-public and private facilities, suggest a gross underfinancing of public hospital care (Lewis, 1988). Quality of care is lower in the underfinanced public facilities when compared to the quasi-public, but better financed University Hospital. A recent study showed quality to be particularly poor in lower level hospitals (Ross Institute Report, 1986). The shortage of resources has contributed to deteriorated physical infrastructure and inadequately functioning equipment in public hospitals.

Private health care provision is divided into two markets, one for ambulatory care, the other for hospitalization. The former serves all income groups, largely

on a fee for service basis, and is expanding. The demand for private outpatient care and the willingness of users to pay for it is well established in Jamaica (McFarlane and McFarlane, 1987). Well over a third of outpatients use private facilities and the numbers are increasing. Public clinics are infrequently used, and public hospital use is declining largely in favor of private and public outpatient care.

Private hospitals are far more costly for patients than public facilities, and private hospitals treat less than five percent of all inpatients. Private patients are more likely to have insurance coverage; however, the lack of catastrophic coverage under most Jamaican insurance plans results in high utilization of public facilities to husband coverage in case of an emergency and total reliance for extended hospitalization (Lewis, 1988). The result is an implicit public subsidy of private insurance companies.

Only one of the seven private hospitals is operating at a profit. Private hospitals are plagued by poor management and antiquated equipment; rising costs due to inflation, devaluation and duties; and a limited pool of potential patients because of declining real incomes and the nature of insurance coverage (Trevor Hamilton and Associates, 1987; Lewis, 1988).

Despite the extensive network of free public health care, 75 percent of patients, in a recent study, indicated that they paid for (some part of) their last treatment (on average about J\$85.00 or US\$15.00). Only 12 percent of that survey population had health insurance coverage (McFarlane and McFarlane, 1987). Thus the majority of users are already paying for health care services. Available evidence further suggests that this practice cuts across all income groups.

B. Project Rationale and Strategy

This Project follows the basic approach set forth in the PID, adopting the Goal and Purpose identified at that time and pursuing most of the specific objectives and interventions proposed. Accordingly, the goal of the Project is to improve the health status of the Jamaican people, and the purpose of the Project is to improve the quality and efficiency of current and future health services delivery. The Project design analyses conducted of the public sector, private sector and health insurance industry have led to some modification of emphasis and identification of some new interventions, intended to maximize achievement of the Project Purpose.

The overall strategy adopted is to build upon the considerable strengths (human, technical and capital infrastructure) of the combined public and private health care services sectors to increase productivity, increase private source revenues, reduce costs, expand coverage, and improve quality of services provided.

More specifically, the Project will: (1) increase efficiency and productivity at public sector hospitals, where 95 percent of Jamaicans receive secondary care, and which account for 61 percent (1986) of government health expenditure; (2) increase revenues at public hospitals from those who can pay; (3) increase the productivity and expand the market for private hospital and medical support services among persons now relying on public facilities; (4) expand private payment of health

care costs through commercial health insurance; (6) increase productivity of private hospitals and their capacity to serve a broader segment of the population; and (7) foster closer collaboration (partnership) between public and private sector health care providers in order to make more economic utilization of the total national health care human and material infrastructure.

It is a complex approach which addresses most key factors now constraining the provision of health care services in Jamaica. However, the Project does not provide two vital resources - additional professional manpower and financial capital. Instead, it focuses on better utilization and/or increased mobilization of existing sources of human and financial capital, public and private.

Public Sector Strategy - The Project analyses have identified a number of important policies which appear to inhibit progress in health care delivery by the private and public sectors. At the same time, the MOH will require assistance in analyzing policy options for the future in terms of identifying appropriate sustainable financing mechanisms, and allocation of public resources in the longer term. Consequently, a major component of the Public Sector Financing component is development of the appropriate policy framework through policy analyses and new/updated health legislation. Examples include import duties and taxes which raise the cost of drugs and medical equipment, incentives to expand commercial health insurance coverage, permission for private physicians to admit patients to public hospitals, and retention of user fees by public hospitals; and feasibility studies of indigent financing mechanisms and social insurance.

Simultaneously, the Project will assist the MOH to implement and operationalize policy options which have been analyzed and proven feasible. For example, the Project will support an expansion in the range and extent of divested support services in public hospitals; and strengthened implementation of the hospitals' cost recovery system.

Private Sector Strategy - The PID anticipated a clear distinction between Project support for the private sector, distinct from the public sector, with the commercial insurance industry seen as bridging the gap. Specifically it anticipated establishment of a Private Sector Expansion Incentive Fund which would extend credit to expanding private sector health concerns. However, the analysis of the private sector's needs conducted during Project design identified a number of constraints, but came to a different conclusion. The major constraints to increased private sector investment in health can be addressed through the adoption of public sector policies and incentives which make investments in health an attractive alternative. One output of the Project will be recommendations for GOJ policy changes which will encourage private investment in health care services and promotion of incentives for increased health insurance coverage.

In addition, the Project will provide technical expertise targeted to specific investments and management changes intended to improve or expand private health care providers', and insurers', capacities to serve the large "public sector market".

Alternatives Considered - The Project activities are described in detail in Section III.B. Project Description. They were identified and defined based on the results of the design stage analyses and selected by the MOH and USAID for

inclusion in the Project because of their anticipated collective and synergistic contributions to achieving the Project Purpose.

Several interventions which are included in the Project activities had been considered in a different mode, but were incorporated into the present structure for administrative viability, or to reinforce the technical and policy objectives of the Project.

As Project design work proceeded, consideration was given to the importance of geographical application and concentration of the activities under consideration. By their nature, some activities require intensive, concentrated implementation in one or a few hospitals, parishes, or other zone, for all or part of their implementation, whereas others have Island-wide applicability only. However, it was determined not feasible, nor necessary to the attainment of the Project objectives, to attempt to concentrate a predetermined set of activity interventions in one or several Parishes or hospital regions. Appropriate geographic and institutional allocation of Project resources will be made as part of the Project planning and implementation process, depending on technical and policy requirements.

C. Project Relationship to GOJ Development Plans and to USAID Strategy

1. GOJ Health Sector Strategy - The Government of Jamaica's health policy is to develop a comprehensive national health service that incorporates both the public and private sectors and provides all Jamaicans with access to the services enabling them to enjoy good health. The GOJ's highest priority is the establishment of an effective primary health care system throughout the country, and increased efficiency in secondary and tertiary levels of care. Increased fiscal constraints during the past decade have forced the GOJ to recognize the importance of cost-effectiveness in health sector planning.

In early 1989 the Peoples National Party was elected to govern Jamaica based on a platform of "Putting People First", with particular emphases on the health and education sectors. The PNP government has stated that its administration will emphasize the optimal use of already limited resources, and concentrate on preventive and health promotion activities. They also recognize that the effective organization and administration of the health services is critical to any enhanced delivery of service. Their stated priorities in the health sector are to address the management of the health system including decentralization, the provision of drugs, the status of health workers, and private sector participation.

2. GOJ Policy and Actions in Health Care Financing - The need to devise alternative means of financing and delivering health care is of paramount concern to the government, and health care financing is a priority for the MOH. MOH initiatives to date include:

- (a) Revision of user charges in public hospitals and a modification of Jamaican law to allow those facilities to both spend earned revenue and not jeopardize future budget allocations;

(b) Divestiture of nonmedical services. Housekeeping services have been divested in three tertiary care hospitals saving J\$374 million, or roughly half the budget, and raising quality. Catering and laundry services are also to be divested in these three facilities as well as four others. In addition, the National Maintenance Unit is slated for divestment so that facilities can rely on contractors for maintenance services;

(c) Examining privatizing public hospitals experimenting with three approaches: (a) management of a hospital with the entrepreneur assuming all financial risks; (b) management by a private group with the MOH assuming the financial risk; and (c) establishment of a parastatal hospital with private operation, management and control but with government holding a majority share. In the latter case, facilities and public medical employees would exist in a Health Facilities Trust that would allow government to own but not operate facilities and would allow management to set salaries for all staff; and,

(d) Administrative and financial management reforms that introduce performance based budgeting, computerization to improve financial management, and rationalization of facilities (downgrading or reducing bed size of public facilities).

USAID assistance has supported a number of GOJ activities: studies (see Annex I) that address policy concerns in health care finance (e.g., Steven, 1983; Project Hope, 1985; Zukin and Weinberg, 1986), evaluations of MOH experiments (Lewis, 1989), and periodic technical assistance in the development of policy and MOH experiments in financing. In addition, USAID has examined the role and efficiency of the private sector in the delivery of health care (Trevor Hamilton and Associates, 1987; Lewis, 1988; Barnes, 1989).

3. USAID CDSS and Health Sector Strategy - Given that the relatively healthy population is regarded as an asset for economic development and productivity in other sectors, the CDSS emphasizes strategies to assist and upgrade the quality of health care service delivery in Jamaica. A key strategy element of the CDSS is the development of human capital which is directly dependent on the health of the population. By strengthening the private sector's role in health services provision, the Project will reduce the burden on the public sector thereby allowing a more efficient use of limited resources on the remaining public health services, especially for primary health care, and on improvement in the quality of health services.

USAID's CDSS health strategy concentrates on three broad areas:

- (1) develop and implement alternative means of financing and delivering health care services, including privatization and private sector approaches;
- (2) prevent and control STDs and AIDS; and
- (3) concentrate population funds in areas where health gains are greatest.

The Project will address the first component of the strategy (other projects address the latter two) while building on the activities to be completed under the USAID funded Health Management Improvement Project (HMIP), particularly in the

areas of alternative financing and management, and rationalization of health care facilities and staff. The HMIP is focusing on long term strengthening of health sector administration by assisting the MOH in beginning the process of determining cost-effective and efficient means of maximizing health status with limited available resources. Project activities have focused on management training, development of management procedures, improved working conditions for health professionals in primary health care facilities, development of a comprehensive health information system to facilitate better national health planning, renovation of selected health centers, and the purchase of pharmaceuticals.

D. Relationship to Other Donor Programs

Other international donors are active in the health sector in Jamaica. A seven-year World Bank Population and Health Project, which got underway in January 1988, has a health improvement component to strengthen health management systems, restructure referral systems, and improve cost recovery and health financing systems. The Pan American Health Organization's (PAHO's) ongoing program of technical assistance, training, research and environmental health has made important contributions to the health sector in Jamaica, particularly in the areas of health manpower assessment and planning, and hospital management. UNICEF supports a variety of small-scale community projects, health education programs, and primary health care research as part of its ongoing program of assistance in Jamaica. UNICEF also assists the GOJ with procurement of supplies and equipment for the Jamaican health sector, including oral rehydration therapy packets. The GOJ is negotiating a loan from the Interamerican Development Bank for the upgrading and restoration of six hospitals, as well as a grant-financed Technical Cooperation Component. The Technical Cooperation Component, if approved, will assist the MOH in developing management systems in the areas of budgeting and accounting, maintenance, quality assurance, supply and transport management. It is anticipated that the Project will start-up in the fourth quarter 1989, consultancies will begin in mid-1990 to design these systems, and implementation would take place in 1991 and thereafter. The Italian Government is assisting with rehabilitation of the Bustamante Children's Hospital, and Spanish Town and Victoria Jubilee Hospitals with particular attention to the maternity blocks. The European Economic Community (EEC) is providing grant funds to finance a new central laboratory building scheduled for completion in 1990, equipment and vehicles.

The Health Sector Initiatives Project has been developed with consideration given to complementing these other donor financed projects. The Project will build upon and complement these programs and activities by its tight focus on changing systems to get better total service delivery at relatively constant recurring budget levels of Jamaican dollars.

III. PROJECT DESCRIPTION

A. Project Goal and Purpose - The goal of the Project is to improve the health status of the Jamaican people. This goal is consistent with the LAC Bureau objective of improved health and child survival.

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The purpose of the seven-year Project is to improve the quality and efficiency of current and future health services delivery. This will be accomplished by:

- (1) increasing the efficiency of the GOJ in the provision of health services; and
- (2) increasing the proportion of health care services delivered and financed by the private sector.

By PACD, the Project is expected to achieve:

- 300 percent increase in collection of hospital fees;
- Percent population covered by health insurance increase from 15 percent to 25 percent;
- Admission to private hospitals or private wings of public hospitals increase from 1 percent of all admissions to 10 percent;
- 10 public/private partnerships in place (i.e. privatized support services, public purchase of lab services, etc.)
- Improved quality of service in public sector as measured by patient waiting time, availability of pharmaceuticals, ratio of staff to patient, efficiency of inputs to outputs.

B. Project Accomplishments - The Project will address the problem of insufficient public resources to provide free health services for all citizens, regardless of income;

The objectives are:

- to spread the financial burden of health care costs by tapping additional resources; and
- to improve the quality of health care services.

The Project will work simultaneously with the public and private health sectors.

Project Outputs in each of the components of the Project include:

Public Sector Financing

--Policy Framework

- . A series of analyses to assist the GOJ in taking policy decisions which facilitate sustainable mechanisms for financing of health care in Jamaica.
- . Updated health legislation to support management, efficiency, and financing mechanisms.

-- More Efficient Cost Recovery

- . Administrative systems in place to collect hospital fees and insurance payments.
- . Increased revenues.
- . Revised policies for fee structures and retention and utilization of fees by the collecting facility.

-- Social Marketing

- . Improved knowledge, attitude and practices of health consumers, providers, employers and labor unions with regard to health services utilization, drug costs and utilization, health insurance coverage, and public sector health policies.

Public Sector Management

-- Headquarters Strengthening

- . Restructuring of headquarters resulting in improved planning and management capability.
- . More efficient financial, personnel, and support systems in place due to modern management technologies.

-- Alternative Management

- . Decentralized management structures in place for primary and secondary care.
- . A target of 10 divested hospital support services resulting in cost saving and improved quality.

-- Primary Care

- . Rationalized primary care services in all parishes through redeployment of staff and improved facilities' utilization.
- . Operations research studies complete which demonstrate cost savings and quality of care improvements.

--Secondary Care

- . Improved management of secondary care facilities through staff training and management assistance.

Private Sector

- . Recommendations for GOJ policy to encourage private investment in health care services.

17x

- Three feasibility studies completed for new private sector investments in health care.
- Improved financial viability of private hospital sector in Jamaica facilitated through management improvements and training.
- Increased health insurance coverage through improved product packaging and marketing.
- Improved capacity of private health sector to work in partnership with public sector.

C. Project Outline and How It Will Work - The public sector components of the Project will assist the MOH with continued implementation of financing and management initiatives which have proven successful in the past, and with analysis of policy options that represent new directions for the future. The primary focus of these components is to assist the MOH to plan and implement initiatives for improved management and financing of the health services. Because the public sector continues to provide the majority of health services in Jamaica, particularly secondary and tertiary, and is the major financier of health services, it is critical to achievement of Project objectives that public health services be upgraded.

At the same time, the Project will begin the process of assisting the GOJ to analyze and understand the potential role which the private sector can play in the financing and provision of health care services in the long term. The Project will promote, through policy dialogue and through direct assistance, an expanded private sector role in the delivery of health care and an expansion in the percentage of the population covered by health insurance. As insurance coverage rises, the demand for private facilities will rise, even where public care is an option. Insurance is therefore a key element in efforts to promote private health care. As documented by Lewis (April 1988), the availability of Government subsidized "free" health care and "free" catastrophic health care are impediments to expanded private insurance coverage and rational financing in the overall sector.

The Project will increase the proportion of health care services provided by the private sector by systematically addressing the constraints to an expansion of this sector. By encouraging private individuals, companies, and groups to invest in health, some of the financial burden for health care can be shifted from the public sector, at least for that segment of the population that can afford to pay, and for those services for which the private sector has a comparative advantage. The financial and management efficiency of those services for which the public sector has a comparative advantage are being addressed by the previous components.

This component of the Project will analyze the extent to which current public sector policies constrain the growth of the private health care sector and outline the various policy options available to the GOJ; and provide technical assistance, training and marketing assistance to facilitate increased health insurance coverage and an increased role for the private sector in providing health care services.

1. PUBLIC SECTOR - FINANCING

a. Policy Framework (\$415,000)

This component of the Project will assist the GOJ to analyze a variety of policy options, and to implement these options through updated legislation in order to put in place a policy framework which supports improved financing and management of the health services.

(i) Policy Analyses: The Project will assist the GOJ in analyzing the various policy options--in particular policies which promote private sector health care investment, expanded health insurance coverage and financing mechanisms for those unable to pay for their health care. The studies will provide the analytical foundation on which to base subsequent policy decisions. A number of policy issues that relate to health care financing have received little if any attention, and deserve some consideration as the debate on how best to finance care proceeds. The selected topics are illustrative:

Defining the Indigent - Assessing the ability versus the willingness of persons to pay for health care can be examined at an aggregate level by analyzing the World Bank financed Jamaican Living Standards Measurement Survey (LSMS). Data from the survey can help determine the linkage between income and health seeking behavior of all income groups, including the determinants of health care utilization across private and public sources, and willingness and ability of patients to pay for health care. This information will help to address the concern that those whose public fees are waived can and do purchase private health care services. Gaps of importance to government planning and program development could be addressed through a focused add-on survey, piggy backing subsequent LSMS rounds, or developing a direct registry of indigents at facilities. This study is supportive of the Project's activities in the areas of User Fee Reforms, in particular the question of the incidence and level of charges and a revision of the current fee structure.

Analysis of the LSMS and input from the MOH on subsequent rounds of the survey to better focus on health issues of interest is a cost effective means of obtaining data and analysis for priority policy issues. Topics for consideration could include the following: the determinants of health care utilization across private and public sources; the willingness and ability of patients to pay for health care across income, location, age, occupation, third party coverage; the relationship between food aid coverage and use of public and private health care. The analysis would be used to explore the incidence of user fees in public facilities, to examine how households respond to changes in charges and how shifts in income affect the demand for (public) health care.

Financing and Managing Indigent Care - As alternative financing arrangements develop and insurance coverage expands, the management and financing of care for those who cannot afford to pay will become the primary concern of the GOJ. Moreover, if and when public reimbursement of some private health care occurs, some type of financial intermediary may become desirable to ensure equal access as well fiscal control over resources. This study will examine alternative arrangements, studies of feasibility and cost, and design of alternative models for testing by the MOH. Given the complexity of this issue and the fact that it

is closely linked to the indigent study above, analysis and experimentation are warranted early on to plan for its design and introduction.

Social Insurance Feasibility Study - One of the options to be reviewed will be national, or social, health insurance, to determine if a government-funded insurance program to cover the commercially un-insureds is feasible in Jamaica. The study will examine the potential costs, structural options, scope and benefits of a social insurance program. Similarly, hybrid public-private insurance systems will be considered and analyzed for comparison purposes. The analyses will estimate the number of persons eligible for such programs, estimate health services utilization and costs, assess the administrative requirements, and estimate impacts of alternative arrangements on cost savings, equity and quality of care. Recommendations for appropriate courses of action will be made to the GOJ.

Incentives for Health Insurance Expansion - A major objective of this Project is to assist the insurance industry and GOJ to expand commercial coverage to all those capable of paying the premiums. This study will analyze the incentives which Government could give to employers and insurers to provide health insurance benefits, and provide recommendations to the GOJ on appropriate policy and regulatory measures to foster expansion of an effective commercial health insurance industry. Policy incentives could include preferential tax treatment of employer contributions to health plan premiums, requirements that employers of more than X number of employees must offer health insurance as an employee benefit, encouragement for labor unions to accept health insurance benefits in lieu of wage increases, etc. Review is also needed of current MOH policies (e.g. public hospital pricing) to determine the extent they are a disincentive to expanded private provision. The analysis will include computer-based simulations of costs and savings of alternative insurance stimulation policies.

Regulatory Role of Government with Expanding Privately Provided Health Care - If the private sector takes on a larger proportion of health care delivery in Jamaica, the government's role will shift from that of provider and financier of care to a different role of regulator and financier (and possibly deliverer) of indigent and perhaps near-indigent health care. The regulatory functions are not well established and would need to be phased in depending on the direction and speed of private sector growth. For example, overseeing the accuracy of laboratory tests, ensuring that private hospital providers meet basic standards of medical practice and that the hospital environment is properly maintained are the kinds of regulatory interventions that might be required. Some exploration of the possible actions and means of enforcement deserve consideration as well.

Health Care Implications of Aging in Jamaica - The aging of the Jamaica population and the government's policy of not charging pensioners has potentially serious financial implications for the MOH. Moreover as the birth rate continues to decline, the demand for hospital care will shift away from maternity. Given the dearth of nursing homes, hospitals are at risk of becoming chronic care facilities for elderly patients who cannot be cared for adequately at home but have nowhere else to go other than the hospital. This planning for future delivery and organization of health care services is meant to ensure more cost effective service delivery without neglecting the needs of the elderly.

Pharmaceutical Procurement - Government drug procurement policies and practices will be analyzed and changes recommended to improve efficiency and reduce consumer costs. Recommendations would entail changes which the GOJ could make in current systems for the procurement of drugs which would result in cost savings. In particular, the analysis and recommendations will examine measures to provide financial incentives for use of generic drugs. These studies will be carried out by the MOH in conjunction with Jamaican and/or U.S. technical assistance.

(ii) Health Legislation: As the MOH begins to redefine its functions in the delivery and financing of health care, new laws will be required and legislation currently on the books will require updating. For example, an expanded role of the Regional Hospital Boards in the planning and management of hospital services will require a revision of the amended Hospital Act of 1963. In a similar vein, cost containment of pharmaceuticals will require preparation and passage of a Generic Drugs Act. This component will ensure that policy decisions which require legislative enactment will be implemented. In other instances, many laws need to be written or revised, and regulations need to be formulated from existing laws. The laws and/or regulations that require revision or enactment include the Public Health Act of 1974, the Dangerous Drug Act, the Excise Duty Act, the Coroner's Act, the Food and Drug Act, the Auxiliary Health Personnel Licensing Act, the Food Protection Law, the Meat Inspection Law, a Generic Drug Act, the Pesticide Control Act, and other legislation relating to Reporting of Communicable Diseases, Mental Health, the Export of Jamaican Foods to the U.S., the Use of Water Resources, Mandatory Immunization, and the Transportation of Hazardous Wastes. Some of these date back over fifty years. The Project will assist the MOH with identification of areas requiring amended and/or new legislation, and with the preparation and submittal of briefs to the Attorney General's office, which then drafts the actual legislation on the basis of the information contained in the brief.

b. More Efficient Cost Recovery Through User Fee Reforms (\$259,000)

This component will implement improvements in user fee administration in public facilities, and promote a revised system of charges which more closely approximates the real costs of providing those services. User fee reform activities will encompass the Administrative System, Adjustment of the Fee Structure, and the Retention/Utilization of Fees.

(i) Administrative System: This will result in streamlining of the administration of fees from the central government and training and group seminars for both medical and administrative staffs in order to develop better collection systems.

System Design - A national workshop with relevant hospital personnel will be organized in the first year in order to gather information on current practices of collecting hospital user fees, with the objective of designing a standardized system for fee collection. It is anticipated that the seminars will allow facility managers and fiscal personnel to share experiences across hospitals in the alternative arrangements used to identify paying patients, tracking them, collecting the charges, handling the revenue, and requesting reimbursement from the MOH, and will suggest means of designing appropriate systems. Moreover, exposure to Jamaican public hospitals that have been effective at collection will encourage the less effective facility managers to rethink their own systems. This exchange would further help to adapt administratively correct procedures in

revenue collection and management to the context of Jamaican public hospitals. Technical assistance will be provided during the first year to finalize the design and the administrative requirements of the fee system.

System Implementation - Implementation of the system will be accomplished through initial training seminars for the collection agents, hospital administrators, assessment officers, controllers, accountants and accountant assistants at all public hospitals (except Bellevue), with follow-up seminars planned three times during the life of the Project, beginning in the first year.

In addition, follow up visits to designated hospitals by the trainer(s) and relevant Project staff will occur at six month intervals after the training to assist hospitals with the start-up and operation of their new systems. The benefits, which will be derived within months after training, will be quantified by the increase in revenue and the efficiency of collection and transmission to the MOH.

(ii) Adjustment of Fee Structure: This will result in adjustments in charges to remove incentives for extended inpatient stays and unneeded tests; charges for insured patients will be set closer to those of the University Hospital; and an increase in the prices charged.

The results of the policy studies completed in the previous component will provide information in support of user fee reform activities, in particular the level of fees, and determination of billable items. The level of fees should bear some relationship to other Project elements: charges should be linked to some degree to the costs of services, primary care referral arrangements can be strengthened by establishing higher charges for those who unnecessarily bypass public clinics, and expansion of those covered by insurance will add to public revenues, particularly if the reforms proposed here are implemented.

(iii) Retention and Utilization of Fees: This will design alternative facility reimbursement arrangements (for deposited revenue); increase the percentage of fees which the collecting facility retains; and develop revised guidelines on the utilization of retained fees.

Policy dialogue will be pursued on decentralization of greater management and budgetary authority to facility managers; an increase in the proportion of fees collected allocated to the collecting facility; and preparation of revised guidelines on the use of retained fees to support improvements in health services delivery.

The anticipated outputs of this component are administrative systems designed and in place in public hospitals to collect hospital fees and insurance payments; increased revenues available to the MOH and the collecting facility; and revised policies analyzed and in place for fee structures, and the retention and utilization of fees by the collecting hospital.

c. Social Marketing (\$385,000)

Achievement of the Project objectives will depend upon many persons making fundamental behavioral changes. Sectoral analyses reveal that health services

consumers and providers follow cost-ineffective practices which drive up health care costs and cause over-utilization of some sector resources and under-utilization of others. Health services consumers must become more cost conscious, seek health insurance, pay for services received (if able), seek health care at appropriate sites, etc. Health services providers must also become more cost conscious, and improve efficiency and productivity. Employers and unions must agree to collaborate with insurers to provide and pay reasonable premiums for comprehensive health insurance with strong cost containment mechanisms built in.

Many, if not all, of the "inappropriate" practices are actually rational responses to constraints in the sector which must be addressed also. For example, patients bypass clinics and overload hospital casualty departments because there are no doctors or drugs at the clinics. Consequently, the MOH cannot expect to achieve positive behavior changes without making concomitant structural or service delivery improvements also. The Public Sector Efficiency component of the Project will address service delivery constraints in primary and secondary care delivery. This component will address some of the principal behavioral constraints that negatively impact on the sector.

This component will address four principal Project concerns: proper services utilization, drugs (pharmaceuticals) costs and utilization, expanding demand for health insurance coverage (especially managed care), and public sector health policies including alternative management. Other priority issues may be added during the course of Project implementation. It will focus on four specific target groups, according to the subjects and strategies developed: health consumers, health providers, employers, and labor unions. Some activities will be aimed at audiences Island-wide, and others will be targeted to specific Parishes or other limited geographic zones according to the particular objectives.

Although detailed approaches and strategies will be determined later, as explained below, the following illustrate the nature of this component. The sub-activity aimed at rationalizing services utilization will describe the proper uses of primary care and secondary facilities and explain that inappropriate use raises costs and reduces services received. The health insurance sub-activity will explain the benefits of private health insurance, the importance of cost containment measures, and the ramifications of insurance abuse.

The Project will contract with a social marketing contractor to plan, design, implement and evaluate the "projects". The Project's New Initiatives in Health Financing and Management Secretariat will be responsible for coordinating the Social Marketing Component of the Project with other related activities supported by the Project. The Project will finance market research studies and pre- and post- Knowledge, Attitudes and Practices (KAP) surveys to measure the impact of these activities.

In certain instances, face to face communication through seminars and in-service training will provide a more appropriate vehicle for educating the target group than the use of mass media. An example of this would be the current prescribing practices of physicians. In this case, it would be most appropriate for representatives of physicians (private & public sector), pharmacists, pharmaceutical companies, UWI Medical School and Pharmacy School, and nurses to collaborate with the MOH on technical and policy issues related to prescribing and

dispensing activities, and become active collaborators in design and implementation of the marketing strategy.

The outputs of this component will be a series of social marketing activities resulting in improved knowledge, attitude and practices of health consumers, providers, employers and labor unions with regard to health services utilization, health insurance coverage, drug costs and utilization, and public sector health policies. For each "project", concrete knowledge, attitude and practices changes will be defined and quantified in terms of number of persons affected. This component's expected outputs will consist of three to five completed social marketing "projects", with quantified "KAP" changes achieved. The "projects" will be carried out by a Jamaican firm contracted under a Host Country Contract.

2. PUBLIC SECTOR - MANAGEMENT

a. Headquarters Strengthening (\$236,000)

While the Project will assist the MOH with decentralized planning and management of its primary and secondary health care programs on the one hand, MOH Headquarters must likewise be prepared to provide the necessary policy guidance and supportive services to promote these changes. Headquarters will continue to play critical roles in the areas of personnel, budget and accounting, and supply procurement and management. This component of the Project will assist with restructuring of headquarters, and the design and implementation of modern management systems for headquarters' key support functions.

(i) Headquarters Restructuring: The MOH has been considering various options for its restructuring which would facilitate improvements in the planning and management of the health services. This component of the Project will assist the MOH through the provision of local technical assistance, to further define and analyze the various organizational options. Given the nature of this activity, GOJ counterpart funds will support consulting services as needed.

(ii) Management Information System: Provision will be made for the enhancement of the MOH's information framework which will complement the other activities undertaken by the Project. This component will build on the accomplishments achieved under HMIP in this area. Under HMIP, computer hardware and software were procured to automate some of the information requirements of the MOH's Health Information and Epidemiology Units. This Project will procure, install, and train staff to automate the supply management, finance and personnel divisions. In addition, the program will provide modern management technology to other headquarters offices in the areas of information processing and telecommunications.

Expected outputs are a restructured headquarters with improved planning and management capability; improved and more efficient systems in place for MOH's accounting and budget, personnel and supply management systems; and increased productivity of Headquarters staff through utilization of modern office technologies.

b. Alternative Management of Public Facilities (\$638,000)

This component of the Project will assist the GOJ with implementation of a policy dialogue agenda and analyses of various policy options which have been explored or implemented successfully under the HMIP. The GOJ has been investigating the feasibility of several alternative means of transferring management, and to the extent possible, financial responsibility of public hospitals, and related primary care and support services, from MOH to private entities. USAID has been assisting this effort for several years through HMIP. It has provided financial support to the MOH New Initiatives in Health Financing and Management Secretariat (formerly Alternative Financing Secretariat), for a number of studies sponsored by it, and implementation of divested hospital support services. This component will build upon the work done to date and enable the GOJ to pursue and implement the initiatives which have proven feasible under HMIP.

Activities included under this component are: (i) the contracting out of public sector functions to the private sector; (ii) the integration of management of primary and secondary health areas and; (iii) an expansion of the role and authority of regional hospital boards.

(i) Contracting Out: The MOH has already successfully divested selected health care related support services resulting in considerable cost savings, improved quality of service, and a reduction in MOH staff. The Project will support an expansion in the range of services divested and in the number of participating facilities. Specialized US and/or Jamaican consultant services will be provided to the Secretariat to determine an overall master plan for implementation of divested support services over the life of the Project. The Project will provide commodity support, small-scale renovation or other costs associated with the preparations needed to facilitate contracting out. The assistance may be directed as well to private/public contracts for management of professional support services such as radiology and laboratory, or referral of "public" patients to private facilities on a contractual basis.

Technical assistance will be provided for development of an overall plan to divest support services and/or contract private sector management of professional support services including necessary feasibility studies and cost benefit analyses. The Secretariat has already made substantial progress in preparing for contracting out support services in Spanish Town and other hospitals under HMIP. These activities will require continued assistance. Technical services will also include: determination of appropriate contract structures; assessment of what services are best suited for private management; identification of private sector entities capable of undertaking contracts; financial analyses and determination of appropriate levels of risk to be assumed by the contractors, versus government; development of contractor selection criteria; and review of proposals.

(ii) Integration of Primary and Secondary Care Health Areas: The MOH operates two levels of health care that are inadequately integrated: a hospital network and a primary health care network, each with its own regions. Primary care has a network of 372 inter-related Types I-V, health centers which are organized into a total of 47 health districts, under the responsibility of the thirteen parish Medical Officers of Health. The island is divided into four primary health care areas or regions which is intended to provide a decentralized management and

257

administrative system for the parishes in the area. Only one of the four health area administrations has been fully implemented, and the other three only partially implemented. Cornwall (Western area) was developed as a pilot area in the Jamaica Population Project II (World Bank) and is fully operational. In the other regions, there are already some officers in place, but this nucleus needs to be supported by the provision of appropriate staff so that the regions can be officially established.

This Project will support the Ministry's plan to fully implement the four decentralized PHC areas, and over time to develop fully integrated primary and secondary care decentralized regions. The Project will provide local technical assistance to develop the plans; management procedures; lines of authority; reporting relationships and implementation of the new management structures through in-service training, workshops and seminars.

(iii) Expansion of the Role and Authority of Hospital Boards: The secondary care services are provided through 24 hospitals in the public sector: 19 acute care hospitals, University Hospital and four specialist hospitals. The hospitals vary in size and range of services provided. The hospitals are classified as Type A, B, and C according to the level of services and catchment population served. The hospitals (except the Bellevue mental hospital) are organized into 10 hospital regions, each administered by a hospital Board selected every two years by the Minister of Health under the amended Public Hospitals Act of 1963.

The MOH has taken the policy decision to decentralize management and budgetary authority for hospitals to strengthened Hospital Boards. The Project will assist the MOH with implementation of this new organizational framework by providing technical assistance to define the role and functions of strengthened Hospital Boards; recommend the legislative changes needed and a redraft of the Public Hospitals Act. The Project will support development of management procedures including reporting relationships, management and budgetary practices, lines of authority and roles and responsibilities. These will be implemented through technical assistance for organizational development and in-service training.

Outputs include: A number of private/public contracts under which private sector health care enterprises will provide services which were previously provided directly by the public sector. A national master plan for contracted health care services will be developed. The MOH will have implemented a new organizational framework for administration and management of hospital services and decentralization of primary health care administration. Finally, a decentralized administration which integrates primary and secondary care will be designed and in place. The impact of this will be cost savings due to a streamlined and more efficient administration, and improved quality of care.

c. Primary Care (\$126,000)

The Primary Health Care Operations Research (PRICOR) has developed a test model by category of worker to provide maximum efficiency in health delivery at the primary health care level. Under the HMIP, USAID is funding local costs to implement the recommended personnel changes as a pilot project in one parish. The current Project will include funds for evaluating the PRICOR model. Provided the evaluation is positive, the Project will undertake replication of the PRICOR model

in the remaining twelve parishes. The Project will also support other operations research studies to test out improvements in the quality and efficiency of health care delivery.

The expected outputs are rationalized deployment of staff and facilities for primary health care in the remaining twelve parishes resulting in improved quality of care and increased efficiency in the utilization of staff and physical resources. Four operations research projects will be implemented which demonstrate cost savings or improvements in quality of care.

d. Secondary Care (\$684,000)

This component will train hospital administration and other key hospital staff in essential skills for managing and operating Jamaican public hospitals, with an emphasis on establishing clear lines of authority and responsibility within the hospitals and establishing clear written operating standards and procedures. This activity will upgrade the skills of incumbent administrators, clarify roles and relationships among the key actors, and define critical standards and procedures in hospitals to make a marked difference in their performance. The component will be conducted in two phases. Phase one will focus intensively on two public hospitals for one year. Lessons learned from the Phase One effort can then be applied more widely in phase two which will extend the training to managers from all public hospitals. Upgrading of the physical infrastructure to be implemented in concert with management improvements will be financed by the GOJ counterpart budget.

(i) Phase One: The MOH has identified Spanish Town Hospital and Victoria Jubilee Hospital (VJH) as the two pilot facilities. Spanish Town Hospital has received physical upgrading under HMIP in conjunction with management changes and along with VJH is not part of the proposed IDB hospital loan. Victoria Jubilee is the primary maternity hospital on the Island and the primary source of tubal ligations (TLs). Given USAID's priorities in the health and family planning sector, management improvements at VJH will support multiple sector objectives, including upgrading the provision of TLs.

A senior hospital administration advisor recruited from the U.S. will work directly with the Administrators, and other members of the hospital management teams, of these two public hospitals over the course of one year. The Advisor will diagnose the principal management issues facing the two hospitals, identify priority needs for operating standards and procedures, develop on-the-job training strategies intended to build skills, clarify roles, prepare or modify procedures, and carry them out over the twelve month period. This hands-on problem definition and problem solving training will help the Administrators and management teams better understand their roles and responsibilities and encourage them to initiate new practices, guided by an experienced expert. Subjects which may be addressed will include financial administration, personnel management, medical records, quality assurance, patient admissions and triage systems, discharge practices, ambulatory care practices, drug management, equipment maintenance and supplies control.

The Advisor will identify needs and candidates for specific skills development training and recommend formal training sources for obtaining it. The Project will

27x

support short-term training courses, locally or overseas. In addition, the MOH may request assistance for training from other Donors. Such training would complement the work of this component. The Advisor will provide follow-up technical support to the two hospitals in subsequent years of the Project.

(ii) Phase Two: After one year of experience working intensively with the two "pilot" hospitals, the Advisor, assisted by additional experts, will develop a set of training modules based on some of the highest priority issues, to be used in a series of training workshops for administrators and other staff of the other public hospitals. The focus and content of these workshops will be determined in consultation with appropriate MOH officials and Project staff. Participants may include hospital board members, senior medical officers, matrons and other interested parties, as well as the hospital administrators. Targeted seminars may be developed aimed especially at one or more of those groups.

The workshops/seminars will be conducted during years two, three, and four of the Project, following development of their content based on the intensive "pilot" work of Phase One.

Expected outputs are improved management of secondary care facilities through staff training and management assistance.

3. PRIVATE SECTOR

The activities to be supported under this component of the Project are (a) Investment Climate Study and (b) Private Sector Technical Support.

a. Investment Climate Study (\$25,000)

Private investment in health care enterprises is constrained by unfavorable tax and regulatory policies, as compared to other priority economic sectors such as tourism, manufacturing and export agriculture. Health sector investments can help to shift a portion of the national health care burden from the public sector to the private sector. Such a shift, however, will require incentives similar to those currently offered to investors in other sectors.

The Project will support a detailed assessment of the private health care industry, its investment climate and current profitability for different segments of the market. Investment incentives and disincentives, including access to credit, taxes, import duties, and regulations, will be analyzed and their impacts quantified. The analysis will also identify the demand for health services, in terms of level of quality, types of services, and acceptability of fee structures. The analysis will tie in with the Social Marketing component, with differentiation by locality and recommended options to increase market penetration through improved public perceptions of and recourse to private health services.

The study will be conducted by the PSOJ and will result in recommendations to the GOJ for policy changes to encourage private investment in the health care industry.

b. Private Sector Technical Support (\$550,000)

This component which will be implemented by the Private Sector Organization of Jamaica (PSOJ) will provide technical expertise to private health care enterprises, including insurers and HMOs, in support of their investments in management improvements, services expansion or initiation, major equipment purchases, or other improvements required to become financially viable. The component will not provide funds for the capital investments, however. More specifically, the following are among the areas that will be addressed:

(i) Health Insurance Industry Expansion:

Targeted Social Marketing - Programs will be conducted to encourage commercial insurance enrollment expansion, with emphasis on "HMO - like" pre-paid managed care systems focussed on cost containment. Effectiveness of the social marketing approach will be monitored in order to distinguish between its impact on enrollment growth versus the policy incentives impacts.

Product Improvement - Technical assistance to commercial health insurers, and new "HMO" ventures will assist in improving their "product" to meet the national health care objectives. Improvements will include enhanced management efficiency, better provider relations and member services, and expanded enrollments.

Regulatory Guidance - Consultant services will assist the health insurance regulatory body to strengthen its capability to develop a long-term strategy for guiding the health insurance industry in a direction that will best meet the health sector goals.

Cost Containment - Assistance will strengthen insurers' cost containment practices and develop new product lines which will attract more enrollees. Assistance will be offered to develop, or expand, prepaid managed care (HMO-like) schemes, and Preferred Provider Organization (PPO) schemes, because they focus on cost containment.

(ii) Private Health Care Service Providers:

Financial/Management Analysis - Analysis of the present financial and management systems will be carried out, emphasizing planning and monitoring capabilities. Advisors will also work with the private sector facilities to establish short, medium and long range priorities, and specific objectives such as health care services targets, financial targets, and professional development targets.

Operations Review - Identification of problem areas affecting the cost of operating the facility, particularly focusing on financial and management accounting systems and mechanisms, and procedures for operations and maintenance of physical assets.

Service Levels - Optimal levels of service for existing and future demands will be determined. This will involve thorough investigations of fixed costs at the unit/cost center level and a review of the break-even level of services required; surveys of prevailing rates and reviews of the levels of coverage under prevailing health plans when making these determinations; and recommendations for competitive prices for services in each profit/income center.

29X

Profitability - Recommendations for improvements that will increase profitability while maintaining service coverage. These recommendations will be in the areas of systems/approaches (i.e. accountability; planning, monitoring and control; performance assessment; cost control; accounts receivables; break-even; inventory management; maintenance of physical assets, and sample reports); organization structure; staffing requirements; and training requirements. The advisors will also provide recommendations on the mix of services in light of the capability of present and planned physical facilities and personnel levels. These recommendations will be supported by an analysis of the likely impact on revenue with an evaluation of cost-benefit and profitability of providing each service, the compatibility with existing services, and the implications for investment outlay.

Training - Training of staff in all areas of business management, such as marketing, finance and production.

(iii) Other Areas -

New Investments - Feasibility studies in support of new private sector investments in health care services. These will be conducted by local firms with U.S. technical assistance as appropriate.

Public/Private Partnership - Technical assistance and training for private sector firms working in partnership with the MOH in the area of divested support services and public/private partnerships.

Assistance will be provided in the form of a matching grant to an enterprise to pay for consultant services marketing assistance or training. A maximum amount of \$75,000 will be provided to any one enterprise, on a cost sharing basis with the grantee providing 25% in cash or in kind. Typical "grants" will involve feasibility studies, management assessments, market and site selection studies, equipment specifications preparation and review, marketing assistance, and training. Because the present private health care industry is small, excluding individual physician practices, this assistance will be available to almost all of the hospitals, diagnostic centers and laboratories, and health insurance companies as well as to newly formed enterprises. The criteria to be used in providing this support will be developed in conjunction with the MOH to ensure that the overall health policies of the GOJ are facilitated.

The expected outputs are recommendations for revised GOJ policies to encourage private investment in health care services; new private health care enterprises; increased health insurance coverage through improved product packaging and marketing; and enhanced collaboration between the private and public segments of the health care sector.

4. PROJECT IMPLEMENTATION AND ADMINISTRATION

(a) Secretariat Institutional Support (\$752,000)

The New Initiatives in Health Financing and Management Secretariat (formerly the Alternative Financing Secretariat) will be located in the Ministry of Health with responsibility for implementing the Public Sector Activities and for coordinating

the overall Project. The Secretariat will be responsible for administering the Project, coordinating Project activities and the deployment of technical assistance as appropriate. The Secretariat will coordinate the contracting work underway, investigate new financing initiatives, maintain close coordination with other government agencies and private sector organizations, liaise with the technical assistance contractor and monitor overall progress. Funds will be used to pay for the services of a Health Finance Coordinator, a Health Management Coordinator, and support staff. The Project Manager member of the secretariat will be GOJ funded.

(b) Private Sector Coordinator (\$246,000)

This person will be located in PSOJ and will be responsible for coordinating the private sector component of the Project.

5. ANNUALIZED PROJECT OUTPUTS - The following are the expected achievements/accomplishments of the Project on an annual basis:

YEAR 1 (FY90)

- . Policy Studies - Social Insurance Feasibility Study
 - Defining the Indigent
- . National Workshop Held - Standardized system for fee collection designed
- . Design Management Information System
- . Complete Master Plan for Divested Services
- . Evaluate Primary Care Rationalization Project (PRICOR)
- . Recruit In-country Advisor for Hospital Management Upgrading
- . Investment Climate Study

YEAR 2 (FY91)

- . Policy Studies - Financing and Managing Indigent Care
 - Pharmaceutical Procurement
- . 5 legal briefs prepared
- . 3 Training Workshops on Hospital Fee Collection and follow-up visits completed
- . Develop the objectives and RFP for Social Marketing Component
- . Procure equipment and install MIS (Management Information System)
- . 2 Divested Hospital Services in place
- . Replicate PRICOR in 2 parishes
- . Hospital Management Improvements implemented in 2 pilot hospitals
- . Develop Hospital Management Training Modules
- . 5 Technical Support packages undertaken for Private Sector

YEAR 3 (FY92)

- . Policy Study - Incentives for Health Insurance Expansion
- . 5 legal briefs prepared
- . Adjustment and Review of Fee Structure and Retention and Utilization of Fees
- . 1st. Social Marketing Project completed
- . 2 Divested Hospital Services in place
- . Replicate PRICOR in 2 parishes
- . 4 completed Hospital Management Seminars
- . 5 Technical support packages undertaken for Private Sector
- . Primary Care administration decentralized
- . Mid-project evaluation complete

YEAR 4 (FY93)

- . Policy Study - Regulatory Role of Government
- . 2nd. Social Marketing Project completed
- . 2 Divested Hospital services in place
- . Replicate PRICOR in 2 parishes
- . 4 completed Hospital Management Seminars
- . 5 technical support packages undertaken for Private Sector
- . Decentralized Hospital Boards in place

YEAR 5 (FY94)

- . Policy Study - Health Care Implications of Aging
- . 3rd. Social Marketing Project completed
- . 2 Divested Hospital Services in place
- . Replicate PRICOR in 2 parishes
- . 4 completed Hospital Management Seminars
- . Integrate Primary and Secondary Care Administrative Systems

YEAR 6 (FY95-96)

- . 4th. Social Marketing Project completed
- . 2 Divested Hospital Services in place
- . Replicate PRICOR in 4 parishes
- . Final Project Evaluation

IV. COST ESTIMATES AND FINANCIAL PLAN

The total cost of the seven year HSIP Project is estimated to be US\$6,855,000. Of this amount, A.I.D. is expected to contribute resources totalling US\$5,000,000 while the equivalent of US\$1,855,000 will be contributed by the GOJ. First year obligations in FY 1989 are expected to be \$468,000. Contingency has been estimated at 10% of Project costs each year.

A. Summary Cost Estimate and Financial Plan - Table I presents a summary of the cost estimates and financial plan for the total life of project. The GOJ is contributing 27% of Project costs with increasing fiscal responsibility toward the end of the Project. The GOJ contribution will include administrative support (the Project Manager and support staff, office equipment and supplies, renovations, furniture and equipment for hospitals and clinics).

B. Costing of Project Outputs/Inputs - Table II shows costing of Project inputs and outputs.

C. Projection of Expenditures by Fiscal Year - Table III shows the estimated expenditures by component by year.

TABLE I
SUMMARY COST ESTIMATE AND FINANCIAL PLAN
(US\$000)

ELEMENTS		AID		TOTAL	GOJ		TOTAL	
		FX	LC		LC	FX	LC	
1. TECHNICAL ASSISTANCE								
Short Term - US	33pm	782	-	782	-	-	782	-
Short Term - Local	168pm	-	789	789	-	-	-	789
Long Term - Local	204pm	-	896	896	-	-	-	896
		782	1685	2467			782	1685
2. TRAINING								
Local Workshops	19ms	-	228	228	-	-	-	228
Seminars	8ms	-	80	80	-	-	-	80
Others US and Local	9pm	45	90	135	-	-	45	90
		45	398	443			45	398
3. COMMODITIES								
Office Equipment		-	-	-	168	-	-	168
Office Furniture		-	-	-	55	-	-	55
Computer Hardware/Software		100	100	200	-	-	100	100
Others		150	145	295	-	-	150	145
		250	245	495	223	-	250	468
4. RENOVATIONS								
		-	-	-	610	-	-	610
5. PRIVATE SECTOR								
Project Coordinator	60pm	-	246	246	-	-	-	246
Technical Assistance	58pm	250	265	515	-	-	250	265
Training	6pm	-	60	60	-	-	-	60
		250	571	821	-	-	250	571
6. SUPPORT COSTS								
		-	90	90	1022	-	-	1112
7. AUDITS AND EVALUATION								
		199	30	229	-	-	199	30
8. CONTINGENCY/INFLATION								
		228	227	455	-	-	228	227
TOTAL		1754	3248	5000	1855	1754	5101	

TABLE II - COST OF PROJECT OUTPUTS/INPUTS
(US\$000)

OUTPUTS	TECHNICAL	TRAINING	COMMODITIES		RENOVATIONS		PRIVATE	SUPPORT		AUDITS & EVALUATIONS	CONTINGENCY/ INFLATION	SUBTOTAL		GRAND TOTAL
	ASSIST. AID		AID	AID	GOJ	AID	GOJ	SECTOR AID	AID	GOJ	AID	AID	AID	
1 Policy Studies	271	-	-	-	-	-	-	-	-	14	29	314	0	314
2 Revised Public Health Laws	144	-	-	-	-	-	-	-	-	8	15	167	0	167
3 Admin. System for Fee Collection	136	73	-	-	-	-	-	-	-	11	22	242	0	242
4 Revised Fee Structure	50	-	-	-	-	-	-	-	-	8	6	58	0	58
5 Social Marketing Campaigns	305	80	-	-	-	-	-	-	-	20	41	446	0	446
6 HIS - Headquarters	36	-	200	-	-	-	-	-	-	13	25	274	0	274
7 Headquarters Restructuring	-	-	-	73	-	-	-	-	102	-	-	0	255	255
8 Master Plan for Contracting Out	39	-	-	-	-	-	-	-	-	2	4	45	0	45
9 Divested Support Services	84	-	295	-	-	-	-	-	-	20	40	439	0	439
10 Health Admin. Reorganized	120	100	-	-	-	103	-	-	-	12	23	255	103	438
11 Replication of PRICOR	36	-	-	-	-	-	-	80	-	7	13	146	0	146
12 Training Programs-Hospital Admin. and Staff	494	190	-	55	-	427	-	-	-	36	72	782	402	1274
13 Investment Climate Survey	-	-	-	-	-	-	25	-	-	1	3	29	0	29
14 Private Sector Health and Insurance Provider	-	-	-	-	-	-	796	-	-	42	84	922	0	922
15 Health Initiatives Secretariat	752	-	-	95	-	-	-	-	840	40	79	871	935	1806
TOTAL	2467	443	495	223	0	610	821	90	1022	229	455	5000	1855	6855

557

TABLE III
 PROJECTION OF EXPENDITURES BY FINANCIAL YEAR
 (US\$000)

	FY 89		FY 90		FY 91		FY 92		FY 93		FY 94		FY 95		FY 96		TOTAL	
	AID	GOJ	AID	GOJ	AID	GOJ	AID	GOJ	AID	GOJ	AID	GOJ	AID	GOJ	AID	GOJ	AID	GOJ
1. TECHNICAL ASSISTANCE	36	-	805	-	444	-	309	-	309	-	278	-	164	-	122	-	2467	-
2. TRAINING	-	-	36	-	132	-	120	-	105	-	40	-	10	-	-	-	443	-
3. COMMODITIES	-	37	200	55	59	26	59	25	59	26	59	26	59	14	-	14	495	223
4. RENOVATIONS	-	-	-	214	-	274	-	61	-	61	-	-	-	-	-	-	-	610
5. PRIVATE SECTOR	8	-	93	-	193	-	193	-	193	-	141	-	-	-	-	-	821	-
6. SUPPORT COSTS	-	-	30	79	30	160	30	159	-	159	-	160	-	160	-	145	90	1022
7. AUDITS AND EVALUATION	10	-	-	-	-	-	100	-	-	-	10	-	-	-	109	-	229	-
8. CONTINGENCY/INFLATION	4	-	116	-	86	-	77	-	67	-	56	-	33	-	16	-	455	-
TOTAL	58	37	1200	348	944	460	888	245	733	246	584	186	266	174	247	159	5000	1055

D. Methods of Implementation and Financing - The methods of implementation and financing listed in Table IV are all in accordance with the Agency's payment verification guidelines. The Ministry of Health will be the GOJ implementing agent and will be responsible for all host country accounting and financial reporting and contracting for goods and services. Funds will be disbursed by USAID to the MOH under the reimbursement basis. The MOH is currently implementing the Health Management Improvement Project and their accounting and reporting capabilities were reviewed on several occasions by the Mission's Financial Analyst staff and were found adequate as were their ability to comply with host country contracting procedures. The Mission will contract with a local Chartered Accounting Firm to conduct a follow-up review during the first Year of implementation.

The Private Sector Organization of Jamaica will assist the MOH in implementing the private sector component of the project. USAID will enter into a direct contract (grant) with the PSOJ and the organization will operate under an advance/reimbursement method of financing. Before signing the grant, USAID will have a Chartered Accounting Firm conduct a review of their accounting, financial reporting and contracting capabilities. The PSOJ previously implemented a grant funded under another project and a prior review found no weaknesses in their capabilities.

Project funds are provided to contract periodically with local chartered accounting firms to perform reviews to ensure that the internal controls, accounting and reporting systems are adequately maintained through the life of the Project.

TABLE IV - METHODS OF IMPLEMENTATION AND FINANCING

INPUT	METHOD OF IMPLEMENTATION	FINANCING	AMOUNT
TECHNICAL ASST.:			
-Long Term Local	H.C. Contract	Direct Reimbursement	896
-Short Term Local	AID Direct Contract	Direct Payment	789
-Short Term -U.S.	AID Direct Contract	Direct Payment	782
TRAINING:			
-Local Workshops	H.C. Contract	Direct Reimbursement	228
-Seminars	H.C. Contract	Direct Reimbursement	80
-Other US & Local	H.C. Contract PIO/P	Direct Reimbursement Transfer of Funds	90 45
COMMODITIES:			
-Computer Hard/ Soft Ware	AID Direct Contract/ PSA	Bank L. Com/Direct Payment	200
-Other Commodities	AID Direct Contract/ PSA	Bank L. Com/Direct Payment	295
PRIVATE SECTOR	Direct Grant	Advance/Reimbursement	821
SUPPORT COSTS	H.C. Contract/PIL	Direct Reimbursement	90
AUDITS/ EVALUATIONS	AID Direct Contract	Direct Payment	229
CONTINGENCY/ INFLATION			<u>455</u>
TOTAL			5,000

V. IMPLEMENTATION PLAN

A. Project Management Responsibilities and Organization - The following section outlines the responsibilities of the key players. Specific implementation steps of the activities are described in further detail below.

Public Sector - Responsibility for the Public Sector aspects of the Project will be lodged in the New Initiatives in Health Financing and Management Secretariat in the Ministry of Health. The Secretariat will be responsible to the Permanent Secretary of the MOH who is designated Project Director. The function of the Secretariat will include Project related administrative responsibilities which will be carried out with the addition of GOJ funded administrative staff. These individuals are currently located in the organizationally separate PIU of the HMIP. Actual day to day Project implementation will be the responsibility of a GOJ funded Project Manager who will be assisted by the following Jamaican staff:

- Health Finance Coordinator
- Health Management Coordinator
- Secretary
- Administrative Staff (including an accountant, a Contracts Officer, and a secretary)

Institutional Contract - It is envisaged that all the U.S. and local short term TA will be provided under an AID direct institutional contract. An RFP will be prepared inviting proposals from both Jamaican and U.S. firms for a joint venture arrangement to access the required mix of TA. Individual consultants provided under the Contract will be subject to approval by the Secretariat and AID.

Social Marketing Contract - The Secretariat will work out specific achievable behavior change objectives and, using the institutional contract described above, contract for field research to determine target groups' understanding of the issues, reasons for their current practices, and receptivity to change. An RFP will be developed and a Jamaican firm chosen to implement the Social Marketing activities. A series of media packages will then be developed and executed by the social marketing firm to develop and test messages, determine the appropriate media, conduct the interventions, evaluate the performance, and measure the impact. The Secretariat staff, as well as any short-term technical specialists working on a related component (pharmaceutical utilization, privatization, health insurance coverage, etc.), will work closely with the firm throughout the social marketing process to ensure that the technical quality of the social marketing efforts are maintained, and GOJ policies are adhered to. The Project will seek financial or in-kind contributions from private sector institutions which stand to benefit from this component, such as insurance companies, to defray Project costs.

Private Sector - The Private Sector aspects of the Project will be the responsibility of a Private Sector Coordinator funded by the Project and located in PSOJ. Prior to execution of a handbook 13 grant with PSOJ, USAID will contract a local chartered accounting firm to check if PSOJ's system of internal financial contract and management are adequate.

The PSOJ will be responsible for carrying out the Investment Climate Study, which will assess the environment for doing business in health care services, analyze the comparative position of the health sector in competing for private sector

participation, and provide policy framework recommendations to promote private sector participation.

Under the Private Sector Technical Support component depending on the nature of the activity in some cases, grants will be awarded through a competitive process either in response to invitations from the Private Sector Coordinator and in other cases will be awarded, in response to unsolicited proposals that meet established criteria. Selection criteria will be determined in conjunction with the MOH and will focus on the extent to which sub-activities will increase private sector services capacity, quality of care, market share, coverage of lower income groups, and reduction of public sector health care expenditures, at least in the long run. A special panel of experts will be formed to advise the Private Sector Coordinator on implementation of this component and to review and approve "grant" applications. The panel will consist of a majority of private sector representatives drawn from the PSOJ Health Subcommittee, as well as the MOH delegate.

Depending on the receiving organization's capability, assistance will be provided as a "grant" which the organization will use to procure the services; or directly provided to the organization with the requisite assistance contracted for by the PSOJ Private Sector Coordinator. Under the first option, the applicant will be given a grant to procure appropriate expertise required. The Private Sector Coordinator will assist the applicant to identify and make arrangements with consultants and experts, but their actual selection and hiring will be the responsibility of the applicant. Under the second option, the Private Sector Coordinator will arrange to provide appropriate consultant services required to meet the applicants' requirements, at a cost not exceeding the approved "grant". Under both options, the potential grantee will submit a proposal which will serve as the basis for determining their eligibility to receive a "grant". The proposal will include their proposed 25% cost sharing arrangement in either cash or in-kind.

B. Procurement Plan - The goods and services to be procured by the Project consist primarily of commodities and technical services.

Commodities - The commodities consist of computer hardware and software, office equipment, and equipment which supports divestment of hospital support services such as catering equipment, laundry equipment, etc. AID will contract directly with a Procurement Services Agent to procure all its project funded commodities. The specifications for the equipment procured under the Project will be developed by consultants or MOH staff who possess the requisite technical skills.

Technical Assistance - The MOH and A.I.D. will jointly develop a Request for Technical Proposals for short-term technical services to be provided over the Life of the Project. The RFTP will be advertised in the Commerce Business Daily, AID Bulletin and locally to American and Jamaican firms who will be encouraged to develop joint venture arrangements. Criteria for selection will be developed jointly and a Technical Review Committee convened for purposes of reviewing and ranking the technical proposals received. A USAID direct contract will be executed.

The Ministry of Health will execute Host Country contracts for the long term Jamaican technical assistance required by the Project. These include the Health Finance and Health Management Coordinators in the Secretariat, and the technical assistance for updating Health Legislation.

Similarly, a RFTP and a competitive review of proposals will form the basis for awarding a host country contract for the Social Marketing component of the Project. However, this contract will be limited to Jamaican firms since they have been shown to have adequate capability in this area.

The technical services required for the Private Sector component of the Project will be procured by the PSOJ, i.e. an RFTP will be developed and a firm selected and contracted for the services to be provided. Technical services under this contract will be provided to grantee organizations which do not have the capability to procure their own services; otherwise a line of credit will be provided.

For both components of the Project, the sources for all procurement of goods and service provided under the Project will be the United States or Jamaica in accordance with current Agency policy on Source and Origin of grant-financed assistance.

In the case of procurement of computer hardware and software, approval of the IRM office of A.I.D. Washington will be sought in line with current policy on the value of the procurement.

C. Project Monitoring and Evaluation - Monitoring during the Project will be provided by the Project Manager, who will also be responsible for an ongoing process of evaluating the impact of the Project. USAID has the capability to monitor the Project with one USDH Health Officer and an FSN Program Specialist designated responsibility for backstopping the Project. Project monitoring will ensure that the Project is on track and that necessary reviews are undertaken to evaluate and measure impact. Progress under the Project will be monitored through monthly meetings of the Project Review Committee, consisting of key MOH staff and the USAID Project Officer. Measurement of the Project's progress will be monitored through analyzing the data collected under the World Bank sponsored Living Measurement Standards Surveys, now conducted twice yearly by STATIN, to monitor trends in health care utilization and illness. Access to these data will enable the Project managers to determine differentials in terms of sex, income, and geographical stratification. This survey has been adopted by the GOJ as its monitoring tool to evaluate progress and problems in the implementation of its Social Adjustment Programme. Careful input from the Project Manager on subsequent rounds of the LSMS will allow for the routine collection of the necessary data to determine the impact of the Project on an ongoing basis.

In those cases where training is envisioned, there will be follow-up monitoring of training, with feedback to be utilized in the planning of future seminars or training programs. This monitoring will be included as part of the responsibilities of the trainer(s) and will be ensured by the Project Manager.

39X

In addition, under the Social Marketing component, the Secretariat will develop appropriate baseline indicators of target group knowledge, attitudes and practices about each subject to be addressed. These will be monitored periodically during implementation to measure progress. Impact indicators will also be developed in terms of changes by target groups of health services utilized, drugs purchased, insurance purchased, adaptation to privatized facilities, etc. The Project Manager will be responsible for ensuring that these indicators are reviewed periodically.

It is anticipated that an assessment will take place in year three of the Project. The assessment will determine the extent to which the Project is meeting its objectives of increasing the collection of hospital fees; increasing the percentage of the population with insurance coverage; increasing utilization of the private sector; and improving management and efficiency of public sector health services. In addition, the evaluators will: (a) determine if the inputs are being provided in a timely manner, (b) determine the extent to which planned outputs are being achieved, and (c) provide recommendations on timely corrective actions needed. A final evaluation of the Project will be conducted in year 6. The purpose of this evaluation will be to evaluate the impact of the Project on GOJ health care financing and management reforms. The evaluation will pay particular attention to synthesizing lessons learned for dissemination to AID/W and other countries which are addressing similar health care financing and management concerns.

In terms of USAID/Jamaica's monitoring arrangements, the Project Officer will be the USDH Health and Family Planning Officer. Additionally, the USAID Project Committee will conduct regular assessments of Project progress through the Mission's Semi-annual Review process.

VI. SUMMARIES OF ANALYSES

A. Technical Analysis

Overview - Recent studies suggest that quality of care in Jamaica has been seriously eroded (Stevens, 1983; Ross Institute Report, 1985; Lewis, 1988) due to sharp reductions in the MOH's real budget. Moreover, the hospital capital stock is in serious disrepair, further jeopardizing health care quality. The government is currently providing and subsidizing over 90 percent of all inpatient care, and will continue to provide the bulk of hospital care for the near term. Without rehabilitation, the quality of hospital care will continue to decline due to continuing erosion of existing infrastructure and deterioration of equipment. Although recurrent expenditures are currently underfinanced, the ability and willingness of patients to pay for health care has been demonstrated. Moreover, there are evolving initiatives within the MOH to ensure the sustainability of health programs. The lack of capital investment is the major constraint in MOH efforts to rehabilitate the health care system.

As mentioned, government subsidies cover the entire population contributing to the high costs and underfinancing of public health care. More efficient utilization of government expenditures can be achieved by targeting resources to those who cannot afford to pay and promoting greater reliance on private health services,

especially for hospital care. This, however, requires that private hospital care be both attractive and affordable. There is a serious shortage in the number of trained hospital administrators, and that gap negatively affects the costs, quality, and effectiveness of private hospital care. On the demand side, third party coverage is key to greater reliance on private providers, and catastrophic coverage is central to private inpatient use.

Thus there are supply problems in both the public and private sectors that pose serious threats to the basic quality and quantity of health care services. The government's expenditures in health care are high and will continue to rise, due to public demand, technological upgrading and inflation. Patient demand for free health care will continue unabated unless patients shift to private sources of care. To promote this shift, the Government will need to consider providing the necessary incentives.

Several macro level trends adversely impact the Jamaican health sector. Health care services are currently concentrated in urban centers resulting in health care maldistribution. When the rural patients, who are typically indigent patients, eventually access the public health care system, they enter at a progressed disease level requiring more medically sophisticated and technically intense treatment. The impact of sicker indigent patients entering the system is increased health care cost to the public health care system. As the population ages, the trend to chronic and degenerative disease patterns will accelerate. As chronic disease prevalence increases, so will the public demand for technologically sophisticated diagnostic and clinic laboratory services, as well as specialized physicians. The public sector will thus require additional resources to strengthen its current hospital system.

Range of Public Sector Services and Service Standards - In 1987, the public sector delivered 5.5 million units of health care services, with primary health care accounting for 2.7 million or 49 percent and secondary accounting for 51 percent. Curative, child health, family planning and antenatal care represent the highest demanded services in primary health care while pharmacy, casualty, hospital outpatients, and laboratory services represent the most demanded services in secondary care.

The supply of professional staff, a main source for enhancing the quality of care, is very poor especially among dentists, physicians, registered nurses, and assistant nurses. The ratio of these persons is below the standard specified by WHO. This serious shortage of personnel affects the quality of service in the following ways: some personnel have to perform duties outside their areas of competence; turn-around time at clinics and hospitals is unnecessarily long; and the effectiveness of some personnel is impaired because they have to work excessive hours.

Public Sector Efficiency and Administration - Personnel, who account for J\$86 million or 69 percent of the J\$126 million recurrent budget at hospitals, are significantly under-utilized. Professional personnel for example, who are in short supply, spend over 50 percent of their time on the job doing unrelated activities, e.g. excessive paper work and routine service tasks. These tasks should be performed by the auxiliary staff, who are excessive to the needs. The unproductive time ranges from 36 percent for nurse practitioners to 81 percent for dentists, based on PRICOR's operations research in Jamaica.

The hospitals are very weak in administering the policy of fees for services where possible, collections, and productivity. For example, there is no system for determining the medically indigent or those with ability to pay for services. Consequently, only about 18 percent of the chargeable fees have been collected and a high percentage of patients charged have not been paying because the collection system is ineffective. The hospitals have no system in place to establish adequate costing for services and optimum use of personnel. Fees do not accurately reflect the cost of providing the services. In most cases they represent only a small fraction of those charged by private sector providers or the cash benefits insurance carriers allow for the service.

Key Public Sector Issues: Underfinancing - The public sector is characterized by underfinancing, as per capita expenditure in real terms has decreased. This is due to almost total reliance upon the Consolidated Fund for financing and the failure to recover costs through user fees or third party financing. Underfinancing of the sector results in: deficiencies in physical facilities and equipment; medical staff and nursing shortages due to low salaries; clinical and diagnostic laboratory deficiencies; and shortages of medical supplies and pharmaceuticals.

It is estimated that only 18 percent of the potential collectible hospital fees are collected (J\$5.3 million versus J\$29.0). The failure to recover costs is due to a number of factors: (i) a high proportion of indigents in the population: 44.0 percent of the population is estimated to be indigent (1,041,000) and 35 (817,000) are near indigents; (ii) weak financing administration and management systems for collecting fees resulting in low cost recovery; (iii) absence of productivity or cost of services profiles so that fees proposed under the cost recovery program are not realistic; and (iv) the public's perception that services should be free.

Key Public Sector Issues: Human Resource Shortages - Shortages in the human resources available particularly for the public sector are due to the failure to attract and retain staff. Professional health personnel are poorly paid in comparative and real terms. Depending on the particular category of personnel, they receive salaries equivalent to 36-52 percent of those received by personnel in other positions requiring comparable training, experience, and responsibilities; have poor working environment conditions; and lack support personnel. However, emoluments account for approximately 70 percent of the recurrent expenditure in health.

Shortages of key categories of personnel are also due to limitations in the training programs for these professionals, including: (i) limited capacity for training in professional or specialized training in areas such as cardiology, dermatology, chest disease, neurosurgery, plastic surgery, pediatric surgery, nuclear medicine and psychiatry; (ii) reduction of numerous training programs in recent years for enrolled assistant nurses, nurse practitioners, community health aids, general nurses, dental nurses and dental assistant, health management and public health; (iii) difficulty recruiting trainees due to high admission standards required and the low levels of salaries associated with the positions: pharmacology, physiotherapy, dietetics and nursing administration; (iv) inadequate training programs as is the case for hospital administrators; and (v) overemphasis on professional rather than management training.

The public sector suffers from inefficient and poor quality of care. Public hospitals are not organized to give prominence to cost-effective services and enhancement of quality services. Financial administration is fragmented and poorly positioned. Service improvement oriented functions such as maintenance, staff administration, stores and catering are fragmented and in very low positions in the organization.

There are no incentives for management innovation to secure alternative funding sources or to initiate systematic programs to maximize cost-effectiveness and reduce overall costs. Patient turnaround time in health care facilities is excessive due to inefficient administration of services and staff shortages. Clinical and diagnostic laboratory services are inadequate due to staff shortages, equipment failure and inadequate supplies of reagents.

Size and Composition of the Health Insurance Industry - There are about 333,000 insured persons, with insurance companies being the carriers for 99 percent of that number. The level of insured represents only 14 percent of the population, while the number of policy holders represents only 13 percent of the economically active. The industry earns \$79 million per year in premiums or about \$711 per policy holder. The low level of policy holders among the economically active is mainly because the health insurance carriers promote insurance among larger enterprises or organizations where payroll deduction systems are systematic. This segment of the market is very small and concentrates mostly on the civil service, commerce and financial services, and manufacturing. However, the large and growing informal sector, agriculture, and self employed have not been targeted by the insurance carriers.

There are five key health insurance providers on the island: Blue Cross, First Life, Mutual Life, American Life and Life of Jamaica, with Blue Cross being the leader with over 50 percent of the market. Blue Cross is also the only company providing health insurance services as its only business. Health insurance revenue accounts for 1.1 percent to 24 percent of the premiums earned by other carriers. Blue Cross and American Life are foreign owned and therefore corporate decisions regarding their role in the health services sector have to be endorsed by the U.S. based administration. The other three carriers are, Jamaican owned. In addition to these companies, several large employers self-insure. Approximately fourteen percent of the population is covered by private health insurance.

Four of the companies are indemnity insurance companies that pay health care providers as services are rendered to subscribers. HMO Jamaica (operated by Life of Jamaica) is the only health maintenance organization (HMO) on the island. It pays affiliated providers a set monthly fee per assigned enrollee (a capitation fee). That fee does not vary regardless of the number or types of services that are rendered to a given enrollee.

Characteristics of the Market - Over 60 percent of the potential insurance market has not been realized, primarily due to administrative constraints and inadequate inducement to subscribe to health care insurance. The large and growing informal sector representing over 350,000 adults or 42 percent of the employed, is not tapped by the insurance industry, even though it represents the largest segment of the market. This is because the cost of servicing this segment of the market is

prohibitive and they have no formal payroll system to facilitate easy collections. Failure to access these markets leads to low plan enrollment and either financial failure or the need to set rates beyond the reach of most consumers and employers. Low enrollment results in an inadequate base across which to spread risk resulting in financial difficulty for insurance companies.

Premiums have been increasing at 23 percent annually between 1985 and 1988 primarily because the cost of drugs, which accounts for over 40 percent of claims, has been increasing at 17.5 percent annually. The premiums have however remained competitive, ranging from J\$860 - J\$1,020 per year for individuals and J\$1,480 to J\$1,620 per year for groups.

Key Health Insurance Industry Issues - The industry has a range of concerns that are restricting its growth and role in the health care services. They revolve around the cost of drugs, the lack of a national policy to promote generic drugs and free market trading of drugs, the poor health care services for fee paying patients, and the absence of a suitable environment to promote the role of the industry in health care services. There are no major inducements to subscribe to health insurance because of two key reasons.

- The public sector which provides about 90 percent of the health care services does it almost on a "free for all basis" since less than 15 percent of those receiving the services are required to pay a small fee. This small fee is also too low to encourage patients to find third party payers.
- The quality of services is poor for the paying patient and rarely differs from that received by the non-paying patients.

The lack of consumer education regarding the purpose or advantages of private insurance and inadequate awareness of the importance of health insurance retards and restricts financial support for health care. Difficulty in marketing to certain sectors of the economy such as self-employed and seasonally employed persons is another factor resulting in low enrollment. There is no drive to subscribe to health insurance. The health insurance industry will not grow as fast as it could due to: (i) the lack of pressure to have health insurance; (ii) the private sector role and services are very limited; (iii) the public sector which is more equipped to handle more complex cases charges very minimal fees; (iv) the health insurance sector does not enjoy any fiscal incentive for expanding their services.

All of the health insurance companies plan to introduce more aggressive marketing strategies to increase their share of the market. However, they have no concrete plans for mobilizing those in the "hard to administer" market segment comprising small farmers, self employed persons, or employees in small scale enterprises.

Size of the Private Health Care Sector - Compared to the public sector, the private sector is quite small. There are seven private hospitals on the island, five of which are located in Kingston. They range in size from ten to sixty-six beds with a total bed capacity of only 286. All function as secondary hospitals. The only tertiary care facilities on the island are Kingston Public Hospital and the University of the West Indies, both of which are public hospitals.

There are than five private diagnostic centers and laboratories on the island. These private facilities, however, offer some specialized services that are not available through the public sector or are available only on a very limited basis. Ownership of these centers varies. Some are privately owned by entrepreneurs and one is a joint venture between an insurance company, physicians, and private investors.

Physicians in private practice constitute the largest element in the private medical sector. While the number of physicians and dentists practicing in Jamaica is not accurately known, 1986 MOH estimates placed 420 physicians wholly in private practice. That represented fifty-three percent of the estimated 786 physicians practicing at that time. In addition to those physicians wholly in the private sector, as many as fifty percent of the doctors working in the public sector are estimated to engage in private practice. As a group, physicians are well organized through the Jamaican Medical Association and other societies and associations directed at specific practice specialties. The largest of these specialty associations is the General Practitioners Association with over 400 members. Private pharmacies are another large component of the private health sector. There are 180 private pharmacies in operation in Jamaica.

Private Sector Market and Market Potential - Private health care services are delivered to a broad market. Over eighty percent of persons receiving care in the private sector reportedly come from the working or middle classes. The perceived high quality of private services coupled with reduced waiting times at private facilities accounts for the willingness of many persons to pay out of pocket for care in the private sector. Currently, however, because of the underdeveloped insurance industry, only a small fraction of the estimated potential market has access to private sector services.

Private physicians, representing over half of all physicians, account for the majority of private sector health services consumed and, overall, this segment of the private market is thriving. Approximately forty percent of all physicians visits annually are to physicians in private practice. Payments to private sector physicians represent forty percent of all private insurance claims. Given the limited use of insurance, most persons seeing private providers pay out-of-pocket for services. Private physicians visits are relatively inexpensive when compared to other private health services and persons show a high degree of willingness to pay limited amounts for private health services. When more costly services are needed, the uninsured often move into the public system.

Unlike physicians in private practice, private hospitals, diagnostic centers, and laboratories are not well utilized. Private hospitals account for only one percent of all hospital admissions annually and most hospitals report excess bed capacity. At diagnostic centers and laboratories, current volume for most services is less than fifty percent of capacity. Reasons for poor utilization of these services include: limited private insurance coverage; a lack of understanding among the insured regarding the proper uses of insurance; and high insurance co-payments for non-physician services with a resulting reluctance even among the insured to access these services. It is believed that the market for these services is high and that with increased insurance coverage and a better understanding among the population regarding the proper use of insurance, these services could come closer to achieving their market potential.

Private Sector Finances - Many private sector entities report that they are financially strained, with sector funding coming from individual patient payments and insurance reimbursement. Given the general economic climate in Jamaica and the limited use of private insurance, these funding sources have proven inadequate to cover costs within the private sector.

Several insurance companies are reporting financial difficulty. These difficulties have many causes, including low enrollment and poor provider controls. Low enrollment results in an inadequate base across which to spread the risk of insuring against unforeseen and costly illnesses. When the number of covered persons is too low, one catastrophic illness can have serious consequences for the company. Therefore, rates must be adequate to protect the insurance companies from the financial difficulties that they would experience should some subscribers experience catastrophic illnesses. Current rates are beyond the reach of most persons, absent some form of employer contribution.

Because insurance companies are a major funding source for the private health sector, their financial problems have ramifications for the entire private health system. Financial difficulties have forced many insurance companies to delay claims reimbursement and physicians report that numerous services are not covered by insurers at all. Slow claims payment has proven to be a hardship for service providers and some have ceased to deal directly with insurers because of payment delays. Physicians and other low cost providers can deal with patients on a direct pay basis. Inpatient facilities and providers of other high cost services, however, must continue to rely on insurers for reimbursement. Slow claims payment has had an adverse effect on the finances of these facilities.

In addition to slow claims payment, private hospitals and diagnostic centers face other financial obstacles. These difficulties stem from an inability to generate adequate patient volume, high interest rates, and duty fees that must be paid on imported equipment.

All private hospitals, diagnostic centers, and laboratories report low services utilization. Hospitals' occupancy rates average approximately sixty percent and services utilization for private diagnostic centers and labs is under fifty percent. Because of their high fixed costs, it is generally accepted that occupancy or utilization rates of over sixty to sixty-five percent are needed in order for hospitals and diagnostic centers to maintain financial health. The limited use of private insurance and the government's policy of not reimbursing for care rendered through private facilities have limited the ability of these facilities to generate adequate patient volume.

Existing government policies and high interest rates have made it difficult for hospitals, diagnostic centers, and laboratories to raise the capital needed to purchase and maintain necessary equipment. Interest rates on loans are as high as twenty-seven percent and government duty can comprise nearly forty percent of the total purchase price of new equipment. In its Ministry Paper #48, the GOJ modified the import duty obligations of private hospitals. As of December 16, 1988, the aggregate custom and stamp duty on imports of medical and scientific equipment was reduced from thirty percent of equipment purchase price to twenty percent of price. While this action represents a reduction in the tax burden on private medical enterprises, duty taxes continue to be impediments to sector

growth and high tax rates have led many institutions to indefinitely postpone purchases of new equipment, thereby limiting services availability throughout the private sector. In response to high interest rates and heavy duty taxes, physicians have developed a credit union to finance the start-up of new practices and to fund capital acquisitions.

Manpower and Management in the Private Sector - Within the private sector, pay is better than in the public sector, making it somewhat easier for private providers to attract and retain staff. Still, staff shortages plague private facilities and the island's lack of trained health services administrators has had a negative effect on overall sector performance.

Jamaica does not have any formal hospital or health services administration training programs. As a result, persons managing health care facilities have little or no specialized training in health services management and are often ill equipped to deal with the problems faced by the private health care sector. Within private medical facilities, inadequate management training has led to poor to nonexistent long term financial and strategic planning, inadequate or poorly designed marketing programs, improper or nonexistent management controls, and poor resources management and allocation. These management shortcomings have affected the ability of private sector facilities to perform in the market place and to develop innovative strategies for increasing their market share.

Management inefficiencies are particularly acute among pharmacies where critical drugs are frequently unavailable because of poor distribution systems. Access to drugs has also been limited because of high drug costs. In an effort to improve overall health sector finances and to increase drug availability, both the public and private sectors have supported the increased use of generic drugs. Attempts at increasing generic use, however, have been undermined by the institution of a government tax on generic drugs. The tax, which funds other government programs, has made generics nearly as expensive as their brand name counterparts. As a result, drug costs have remained high and access has continued to be a problem.

Key Private Sector Issues - The private sector faces many problems. Due to the limited use of private health insurance, the government's failure to reimburse private facilities for services, and the availability of government funded care, the private sector has had difficulty expanding its market. Limited services utilization has resulted in inadequate cash flow within the private sector to finance sector services. Sector growth is further limited by high interest rates and government duty taxes that have made it difficult to fund capital expansion and equipment acquisition. Financial problems within the sector are compounded by manpower shortages and management inefficiencies.

Although the private health care sector faces many challenges, it offers many strengths that are not readily available in the public sector. Its emphasis on efficiency and profitability provides opportunities for improved management techniques and enhanced patient care coordination that could not only lower costs but also increase the quality of care delivered. In spite of the management shortcomings within the private sector, components of the private sector can bring management expertise to the public sector. Specifically, insurance companies offer management and health care financing skills that are lacking in the public sector.

B. Institutional and Administrative Analysis

The successful implementation of the Project requires a suitable administrative and institutional framework at the MOH and PSOJ as the primary implementing agencies. These organizations, in turn, must be able to coordinate and implement the Project's activities in conjunction with the hospitals, other public sector institutions and among key private sector players. This analysis summarizes the existing capabilities of these organizations to execute the Project's activities.

The Ministry of Health (MOH) - The MOH has national responsibility for developing and delivering primary, secondary and tertiary health care services. It also operates with an institutional framework to plan, execute and monitor project performance. However, the severe shortage of staff in the project planning and project execution units have been major constraints to the successful implementation of projects and have required the establishment of project specific implementation units.

The project planning unit has no unit head, and the only technical person is engaged in a junior position. The lack of staff restricts its ability to carefully plan the logistics for project implementation or to monitor on a timely basis. Consequently, numerous projects experience delayed start-ups. The project implementation unit is also ineffective due to inadequate staffing. Consequently, much of this responsibility has been undertaken by the Finance Division.

In addition to the technical staffing arrangements, the MOH executes its projects with guidance and monitoring from two project review committees. The advisory/management oriented committee, which meets on a monthly basis, is comprised of the Permanent Secretary, the Director of Finance, the Principal Medical Officer for Secondary Health Care (if applicable to the project), the Project Manager, a representative from the Planning Institute of Jamaica, and a representative from PAMCO, a public sector company. The second committee consists of the same members, but is chaired by the Minister of Health.

Since both the project planning and project implementation units have been so ineffective, project execution arrangements have to be established on an individual basis. For example, HMIP which is a major project being executed by the MOH, is being managed by a special project team. The HMIP team comprises: a Manager (who is a medical doctor), a financial analyst, a construction adviser, a procurement officer, several administrative support persons, a director for the alternative financing component, and a research officer. These last two individuals form the backbone of a Secretariat that was established to handle the staff work required to promote the alternative financing objectives of the Project.

The HMIP will terminate in March 1990, and consequently it is envisioned that the MOH will retain these personnel, as appropriate, to implement the Project, and during the interim period be responsible for implementing both the HMIP and the new Project. The advantages to this are that HMIP personnel are already familiar with USAID and MOH procedures; they have prior knowledge of activities conducted under HMIP, many of which feed in directly to the new Project; and start-up time for the Project will be minimal since the Unit will be staffed and ready to work.

Private Sector Players - The private sector plays a significant role in

49X

production, health services, commerce, health insurance, and other financial services in Jamaica. Institutions include: The Life Insurance Companies Association, the Medical Association of Jamaica, the Private Hospital Association, the Jamaica Employers Federation and the Private Sector Organization of Jamaica.

The implementing organization for the private sector component is the Private Sector Organization of Jamaica. The PSOJ is a voluntary, national organization of private sector associations, companies and individuals, who are concerned with developing a strong and vibrant private sector. It was formed in 1976 to:

- promote the principles of private enterprise and the market system as the most effective model of economic growth for Jamaica;
- advocate equality of opportunity, freedom and reward for personal initiative;
- foster unity and co-operation within the private sector;
- lobby government for policies and programs favorable to the private sector; and
- channel private sector resources to help alleviate the economic and social problems of the country.

In carrying out its aims and objectives, the PSOJ engages in a wide range of social and economic activities through its three main divisions, Economic Research, Human Resource and Enterprise Development, and Communications and Membership. Some of the Organization's activities include publications of in-depth economic analyses and forecasts, helping community groups to start businesses, promoting entrepreneurial education in the schools and lobbying government on behalf of business interests.

At present the PSOJ has an active Health Subcommittee which has successfully implemented projects promoting family planning and the use of generic drugs. Most recently the Committee has been focusing on the plight of the nurses in Jamaica and facilitating actions to address the crisis. The Committee comprises representatives of the Nurses Association, Pharmacists Associations, Private Hospital Association, Health Insurance Industry, MOH, and USAID. The Committee will perform an advisory role for both the public and private sector components of the Project.

The PSOJ is ideally poised to take on a leadership role in promoting increased involvement of the private sector in delivering health care in Jamaica.

C. Social Soundness Analysis

The findings of this analysis are that the Project is compatible with the sociocultural environment and that the impact and benefits of the Project are consistent with overall development objectives in reaching poorer and disadvantaged populations such as women, the elderly and the unemployed. The proposed implementation framework for the project is appropriate and designed to broaden and deepen the public - private collaborative efforts in the

economy. It is a major initiative to facilitate a greater role for the private sector in health care services, as it now accounts for less than 15% of the services provided. The Project's support of cost recovery of expenditure among socio-economic stratas which can afford to pay will also enhance the GOJ's ability to provide improved services to the public.

A recently completed Health Expenditure Survey (McFarlane and McFarlane) found that children under the age of 14, women, the unemployed, the lesser educated, and the elderly, are the most frequent users of public health clinics and health centers. The survey found that women disproportionately use public health clinics: 63% of females less than 14 years of age use health centers versus 56% of males. In the 14-59 year old age groups, 46% of the females versus 29% of the males use public health clinics. In the 60 year old and above age groups, 52% of the females versus 34% of the males use public sector clinics. Users of public hospitals are 55% female and 46% male. Among unemployed persons over the age of 14 years, 33% of unemployed females use public clinics compared to 19% of unemployed males. Compared to those who utilize private facilities, those who utilize public clinics come from households with a large number of children and unemployed as members. In addition, women report more illness than men. A recent survey found that 17% of the females surveyed reported illness or injury in the previous four weeks, compared to 14% of the males surveyed.

The Project will also improve the working conditions of medical personnel in public and private sectors where females make a substantial contribution; 95% of 2,425 nurses are female and 40% of 1,000 doctors are female.

The technical analysis outlines deficiencies in the quality of care given in public facilities due to management and financial difficulties. Assuming the evaluation of the PRICOR Pilot Project is favorable, all 13 parishes will implement the PRICOR scheme which redeploys staff to the health centers within a region to ensure that they are properly staffed and services offered. This will result in better quality of care and savings of time and money of patients since they can obtain services at a lower cost (financial and opportunity).

In sum, it can be concluded that the improvements in the managing and financing of the public health care services, which result in better quality health care will directly benefit the poor, unemployed, females and elderly. Individual private health care professionals who are reluctant to practice economic services are likely to be the only disadvantaged group with the execution of the components relating to (i) social marketing of cost containment drug utilization and competitive insurance coverage and (ii) improved public sector services.

The Project will target private as well as public health care facilities for assistance. This should not be viewed as assistance for generating profits as most private sector health concerns are experiencing major financial difficulties--be they hospitals, laboratories or the health insurance industry. It is likely that women entrepreneurs will benefit from greater private sector participation in health care, as has been the case with the divested support services in three Kingston hospitals where the contractor is

a woman-owned and managed company. However, to the degree to which the private sector health entities can become viable and functional, they will automatically attract the clientele that can afford to pay or which has third party coverage for their care. As stated previously, this will allow the public sector to concentrate its limited resources on providing or financing care for those persons who cannot afford to pay.

D. Economic and Financial Analysis

Background: Economic and Financial Context - Jamaica's economy has not performed well over the last decade or more, although economic circumstances have begun to improve since about 1986. The measures of economic performance over the period indicate that:

- Gross Domestic Product in constant prices is still 10 percent below the peak level reached in 1973;
- inflation increased at an annual average rate of about 18 percent between 1973 and 1988;
- unemployment remained above 20 percent during the 1980's.

Total government expenditure in 1987-88 was nearly one-third of GDP, but this reflects the high debt service of the government. Total recurrent expenditures were at 26 percent of GDP, nearly 40 percent of current expenditures must go for interest payments.

Although MOH has received increasing current dollar support from the government, particularly for operating costs. Real spending by the MOH, has declined significantly during the decade. Between 1984/85 and the budget estimates for 1988/89, the MOH recurrent budget as a percentage of the government budget rose from 7.8 to 9.0 percent, reflecting a relative increase in the government's commitment to health care. The proportion of government expenditures allocated to health has actually declined in total, however, due to the limited capital investment in the sector. The MOH receives much less of the government capital budget, and the neglect of major health infrastructure reflects the negligible capital budget allocations.

Despite the aggregate figures on inflation and expenditure, the effect of macroeconomic trends on the real value of MOH expenditures has been mitigated by the fact that 50 to 60 percent of the budget is allocated to personal emoluments. Public sector wages generally have risen less than the inflation rate over the past five to six years. The attrition of public workers, particularly among the most highly skilled (eg., specialists, physicians and nurses) is linked to low pay and to the deteriorating physical environment, which severely affected the productivity of public health workers. The loss of morale and leadership in the MOH and its facilities may parallel the value of losses associated with inflation and may equal the loss in terms of productivity and lost labor. The cost of other medical inputs (other than wages) has risen more rapidly than overall prices (Taylor, 1988), lowering the real value of the MOH supplies budget.

The allocation of central government funds in health is a particularly important issue because the complementary inputs have been unaffordable and have seriously affected the quality, efficiency and effectiveness of the health care system. Indeed, lack of supplies and drugs have in some cases made labor an ineffective input into health care delivery. As mentioned, personal emoluments claim the single largest portion of the budget. Allocations to supplies, which include drugs, medical supplies, nonmedical supplies and maintenance, remained largely stagnant over the three years, 1983/84 and 1985/86.

In 1985/86 supplies were 15 percent of the budget, down from 18.6 percent three years earlier. During that same period, the Jamaican dollar fell by 105 percent, thereby raising the cost of all imported inputs both medical and nonmedical. Between 1983/84 and 1985/86, drug expenditures rose sharply in most hospitals, which suggests a rise in allocations for drugs forced at least in part by the devaluation. Since the budget figure for all supplies in the system remained close to constant during that period, the rising level of pharmaceutical expenditures required a contraction in resources available for other supplies and maintenance. In short, supply expenditures excluding pharmaceuticals, dropped not only in real but also in nominal terms, seriously affecting public hospital services (see Lewis, 1988 for an in depth discussion of this issue).

Another phenomena of public health finances is the sharp rise in appropriations in aid (revenues raised by the MOH system) over the past few years. Collections went from J\$19 million in 1984/85 to J\$28 million in 1985/86, an almost 50 percent increase. Nineteen-eighty-four was the first year under the new hospital user fee schedule. In 1986 facilities were allowed to claim the revenue, which may account for the rise in appropriations in aid. The revenue retention reflects a reinterpretation of the definition of fee earnings, and allowed hospitals to invest in physical plant repairs as well as medical supplies and drugs (Lewis, 1989). These expenditures provided a cushion, though an inadequate one, to allow facilities to continue operation. Since many hospitals' water and security systems were nonfunctional and whole wings unusable because of faulty wiring, the fee revenues allowed the most egregious problems to be addressed.

Project Purpose - This Project addresses the managerial and economic ills of the current health care system by emphasizing: (1) the raising of revenue and reduction of costs (through increased efficiency) in the public system, with concomitant efforts to remove those who do not need subsidies from totally government financed arrangements; and (2) efforts to enhance the role of the private sector as a provider of health care through initiatives that directly stimulate expansion of private supplies of care, and by broadening health insurance of health maintenance organization (HMO) coverage to stimulate demand for private health services.

These objectives are to be achieved through an integrated set of activities which (1) identify the problem (e.g., measure resource costs, studies of health care financing issues, drug cost containment); and, (2) address the problem (management training, private sector promotion, drug procurement and prescribing practice, user fee reform and accommodation of the indigent,

alternative financing arrangements for public hospitals). Many of these initiatives are experimental in nature and there are plans for intensive evaluation of the costs and benefits of each of these.

Costs and Expected Benefits of Project Components - The costs and benefits of the Project are difficult to quantify given the nature of the Project components. Because the resources are aimed at assisting policy makers in devising more effective policies and translating these into tools for financial and organizational reform of the health care system, and at promoting greater private sector investment in health care, a set of flexible activities have been designed. A comparison between this policy reform type of project and, say, construction is difficult since the expected benefits are too dissimilar.

Benefits will occur at two points: both immediately, i.e., as information to policy makers, and as an input to decision-making that will, in turn, reap further benefits in the future. The assumptions about benefit, however are often based on the assumption that policy makers will act appropriately based on expected outcomes of studies and experiments. This, of course, cannot be guaranteed.

As a package, the components cover the weaknesses of the MOH and provide the government with the resources to identify precisely the nature of problems and to consider and evaluate alternative interventions for addressing the problems. The list is thorough and if implemented as anticipated would provide the government with information that will assist them in designing and reforming health care delivery and finance.

The recurrent cost implications are modest, with the registry of indigents the most significant costs. The loss of tariff revenue could affect other programs, however. For instance, generic drug imports currently carry a heavy tariff that is used to finance the National Housing Trust. Eliminating that tariff would affect housing finance objectives of the government and require alternative sources of funds to be identified for that program.

E. Environmental Analysis

The environmental threshold decision for the Project dated July 29, 1988 is a categorical exclusion as set forth in Annex H.

VII. CONDITIONS AND COVENANTS

The Grant Agreement will contain the Standard Conditions Precedent of a legal opinion and a Statement of Authorized Representatives.

NARRATIVE SUMMARY	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
<p><u>PROJECT GOAL</u></p> <p>Improve health and health services in Jamaica.</p>	<p>National health indices stable or improving:</p> <ul style="list-style-type: none"> --Life expectancy at birth --Infant mortality 	<p>Health Information Statistics, vital statistics, demographic statistics</p>	<p>GOJ policies and programs will be supportive of Project objectives.</p>
<p><u>PROJECT PURPOSE</u></p> <p>To improve the quality and efficiency of current and future health services delivery.</p>	<p><u>EOPS</u></p> <ul style="list-style-type: none"> Improved health service facilities management resulting in reduced costs. Private sector firms contracted to manage an estimated 10 Government health support services. Proportion of GOJ health budget allocated to primary health is maintained at 19%. Proportion of health services delivered by the private sector increased from 15% to 25%. Insured population increased from 15% to 25%. Hospital fee collections increase from 18% to 50%. 	<ul style="list-style-type: none"> MOH records. Review of MOH budget. Management contracts. Outside evaluation. Health statistics. Hospital and health center records. LSMS 	<ul style="list-style-type: none"> The GOJ will continue commitment to increased cost recovery, partnership with the private sector, management improvement, and prioritize Primary Health Care. CP is met on user fees.

NARRATIVE SUMMARY	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
<u>OUTPUTS</u>			
<u>Public Sector Financing</u>			
10 policy studies completed.	Reports and studies are generated.	Completed reports.	MOH commitment to policy analysis continues.
10 new or revised public health laws.	Revised legislation in place.	Legislative review.	Attorney general and processes briefs Parliament processes laws.
Administrative system for fee collection in place in 12 public hospitals.	Increased revenues from fee collection.	Hospital accounting records.	Hospital staff committed to collecting revenues. Means testing is administratively feasible.
Revised fee structure and retention policy in place.	MOH written policy in place.	MOH records.	Ministry of Finance and Ministry of Health are willing to increase fees and change policies.
4 social marketing campaigns completed.	Improved KAP for target groups.	Completed KAP surveys.	Improved knowledge and attitudes result in improved health utilization practices.
<u>Public Sector Management</u>			
MIS in place for headquarters.	Computerized support systems in place.	Site visit.	
Master Plan complete for contracting out.	Support services are divested in a phased manner.	MOH records.	MOH continues policy of divesting support services.

NARRATIVE SUMMARY	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
10 contracts in place for divested support services.	Completed contracts.	MOH records.	MOH continues policy of divesting support services.
Reorganized health administration	Strengthened hospital boards, primary care and integration.	Revised organizational structures.	
Replication of PRICOR in 12 parishes.	Rationalized deployment of staff and facilities in 12 parishes.	MOH records. Site visits.	
12 completed training programs for hospital administration and staff.	Trained staff and administrators.	Training reports.	
<u>Private Sector Alt. Financing</u>			
Completed Investment Climate Survey.	Study completed.	Receipt of study.	Local and expat. T.A.) available on a timely basis.
15 grants in place for private sector health and insurance providers.	Additional health sector services undertaken by private sector.	Project records and reports.	
<u>Project Implementation</u>			
Health Initiatives Secretariat in place.	Functioning Secretariat.	Project reports.	

NARRATIVE SUMMARY	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
<u>INPUTS</u> Long Term TA Short Term TA Commodities Training Local Costs <u>Audits & Evaluation</u> Short term T.A. Contingency	See Budget in Section IV	Project records	Inputs available on a timely basis.

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PID Approval Cable

E.O.,12356: N/A
TAGS:
SUBJECT:CT: USAID/JAMAICA HEALTH SECTOR INITIATIVES PID
(532-0152) REVIEW

1. THE DAEC FOR USAID/JAMAICA HEALTH SECTOR INITIATIVES PID WAS HELD ON TUESDAY, APRIL 26, 1988: THE MISSION IS COMMENDED FOR DESIGNING A PROJECT WITH CLEAR PRIORITIES AND WHICH TARGETS SPECIFIC INTERVENTION AREAS IDENTIFIED IN THE MISSION'S RECENT HEALTH SECTOR ASSESSMENT WHERE A.I.E. COULD BE MOST EFFECTIVE. THE PID IS APPROVED AND THE BUREAU CONCURS WITH MISSION DELEGATION OF AUTHORITY TO APPROVE AND AUTORIZE THE PROJECT PAPER, SUBJECT TO THE GUIDANCE HEREIN AND THE EXCEPTION IN PARAGRAPH 4(D).

2. CLARIFICATIONS:

THE FOLLOWING POINTS WERE CLARIFIED AT THE ISSUES MEETING HELD ON WEDNESDAY, APRIL 28:

(A) HEALTH SECTOR ASSESSMENT - QUESTIONS WERE RAISED CONCERNING JAMAICA'S HEALTH SECTOR ASSESSMENT, SUBMITTED IN OCTOBER, 1987, AND WHETHER A REVIEW OF THE DOCUMENT

HAD BEEN CONDUCTED BY THE BUREAU. LAC/DR/HN ALONG WITH PPC AND S AND T PARTICIPATED IN THE REVIEW, HELD IN OCTOBER, 1987, AND CONCURRED WITH THE ASSESSMENT, WHICH JUSTIFIED THE MISSION'S POSITION TO REMAIN IN THE HEALTH SECTOR AND SELECTION OF THE THE HEALTH SECTOR INITIATIVES PROJECT WHICH ADDRESSES CONSTRAINTS TO QUALITY HEALTH CARE AND COMPLEMENTS AN ON-GOING IBRD PROJECT.

(B) HEALTH SERVICES INITIATIVES SECRETARIAT (HSIS) - SEVERAL QUESTIONS WERE RAISED ON THE OPERATION OF HSIS. E.G., SUSTAINABILITY AND EMPLOYMENT OF PERSONNEL. HSIS PERSONNEL WILL BE CONTRACTORS HIRED BY THE MINISTRY OF HEALTH. HOWEVER, HSIS IS A PROJECT SPECIFIC UNIT AND THERE ARE NO PLANS FOR HSIS TO REMAIN AFTER PROJECT COMPLETION.

(C) PROJECT MANAGEMENT - CONCERN WAS EXPRESSED ABOUT THE MANAGEMENT INTENSITY OF THIS PROJECT AND WHETHER THE MISSION COULD HANDLE IMPLEMENTING TWO MAJOR COMPONENTS.

2(A) - N/A

Response to 2(B) - Secretariat Sustainability:

The Project's New Initiatives in Health Financing and Management Secretariat will merge the functions of the previous Alternate Financing Secretariat and the Project Implementation Unit which were established under the Health Management Improvement Project. Although the Secretariat is a project specific unit and there are no plans for it to remain after Project completion, it is highly probable that there will be other projects and activities that will require their expertise beyond this particular Project.

Response to 2(C) - Project Management:

The Health Sector Initiatives Project as proposed in the PID has been broken into two projects; the Mission decided that on balance, AID/W's point was persuasive. Consequently, the AIDS/STD Project was started last calendar year. The HSIP has built in management capability, including a Project Manager, two local consultants in the Ministry of Health and a Private Sector Coordinator which will facilitate Project implementation.

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PID APPROVAL CABLE

ANNEX B

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Response to 2 (D) - Counterpart Funds:

The IDB Hospital Restoration Project is not yet approved, and therefore is not requiring the allocation of major counterpart funds. USAID and the MOH do not anticipate any problem in the GOJ allocating US\$1.855 million as their counterpart contribution.

Response to 3 (A) Private Sector Involvement:

The private sector has been consulted extensively during the Project's preparation. The implementing agency for the private sector component is the Private Sector Organization of Jamaica, which has a sub-committee for Health consisting of representatives of the private health sector, professional organizations, and the Ministry of Health. Assistance to the private sector will be on a cost sharing basis of 25%.

Response to 3 (B) - Terms of AID to Private Sector:

Based on the technical analysis of the private sector, it was determined that establishment of a Private Sector Expansion Incentive Fund was not necessary. A.I.D. guidelines on assistance to the private sector will be adhered to, and will be on a cost sharing basis outlined above.

3 (C) - N/A

HEALTH CARE FINANCING AND AIDS/STD PREVENTION. THE MISSION PLANS TO USE A PSC AND PRIME CONTRACTOR FOR THE PROJECT AND WILL EXPLORE THIS ISSUE FURTHER DURING PROJECT DEVELOPMENT.

(D) OTHER DONOR ACTIVITIES - OTHER DONORS ARE CURRENTLY FINANCING HEALTH PROJECTS IN JAMAICA WHICH COULD AFFECT THE GOJ'S ABILITY TO PROVIDE COUNTERPART FUNDS TO A.I.D. FINANCED PROJECTS. IBRD IS CURRENTLY FUNDING PRIMARY HEALTH CARE AND POPULATION ACTIVITIES, AND IDB HAS PROPOSED PUMPING HOSPITAL RATIONALIZATION AND RENOVATION. THE EFFECT OF THESE ACTIVITIES THE PROJECT PAPER SHOULD ANALYZE THE EXPECTED GOJ COUNTERPART CONTRIBUTIONS TO ENSURE THAT OTHER DONOR ACTIVITIES DO NOT IMPINGE ON THE GOJ'S CAPACITY TO SUCCESSFULLY IMPLEMENT THE PROPOSED PROJECT.

3. ISSUES RESOLVED:

THE FOLLOWING ISSUES WERE RESOLVED AT THE PID ISSUES MEETING:

(A) PRIVATE SECTOR DESIGN DEVELOPMENT - THE PID'S PROPOSED ACTIVITIES WITH THE PRIVATE SECTOR RAISED CONCERNS ABOUT THE ACTUAL EXTENT OF PRIVATE SECTOR INVOLVEMENT IN PROJECT DESIGN. MANY OF THE PROJECT ACTIVITIES WILL BENEFIT THE PRIVATE SECTOR AND A NUMBER

OF STUDIES WILL LOOK AT HOW THE PRIVATE SECTOR THINKS. A.I.D. HAS OFTEN NOTED THE BENEFITS OF BENEFICIARY INVOLVEMENT IN PROJECT DESIGN. THE MISSION WILL ENSURE THAT THE PRIVATE SECTOR WILL BE BROUGHT INTO THE PROJECT DEVELOPMENT PROCESS EARLY AND WILL EXPLORE THE POSSIBILITY OF CO-FINANCING OF SOME PROJECT ACTIVITIES. E.G., FEASIBILITY STUDIES WITH THE PRIVATE SECTOR.

(B) TERMS OF AID THE PROPOSED PROJECT WILL ESTABLISH THE PRIVATE SECTOR EXPANSION INCENTIVE FUND (PSEIF), TO INCREASE PRIVATE SECTOR CAPABILITY IN HEALTH CARE DELIVERY. ACCORDING TO GUIDELINES ON TERMS OF A.I.D. ASSISTANCE, GRANTS TO THE PRIVATE SECTOR MUST COMPLY WITH SPECIFIC GUIDANCE, ENSURING THAT THE VALUE OF ANY BENEFITS TO BE RECEIVED BY THE GRANTEE WILL BE IDENTIFIED AND ANALYZED. THE MISSION WILL ENSURE THAT THE PROJECT IS IN ACCORDANCE WITH A.I.D. POLICY ON GRANTS TO THE PRIVATE SECTOR.

(C) AIDS/STD COMPONENT - CONCERN WAS EXPRESSED ABOUT THE WIDE ARRAY OF ACTIVITIES UNDER THE AIDS/STDs COMPONENT AND WHETHER THE PROJECT COULD MAKE A

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ANNEX B
PID APPROVAL CARTE

Response to 3 (D) - Hospital Management:

The Project will provide training for administrators and their staff, as suggested by AID/W, as well as technical assistance to the hospital.

Response to 4 (A) - Project Structure:

The decision was made by the Mission to separate the AIDS/STD component out of the overall Health Sector Initiatives Project. This information was transmitted to AID/W per 88 Kingston 005807.

Response to 4 (B) - Funding Levels:

Given concern regarding funding levels, the Project has been extended to a seven-year LOP. In addition, there are no long-term expatriate advisors under the Project which minimizes the need for long term commitment of funds.

MEANINGFUL CONTRIBUTION IN SO MANY AREAS. USAID/JAMAICA WILL CAREFULLY REVIEW THE COSTS OF THE PLANNED ACTIVITIES UNDER THE AIDS/STDs COMPONENT OF THE PROJECT TO ENSURE SUFFICIENT FUNDING IS BUDGETED TO ACCOMPLISH THESE ACTIVITIES AND CONSIDER REDUCING THE NUMBER OF ACTIVITIES ASSISTED AND SEEK OTHER DONOR INVOLVEMENT IN CARRYING OUT SOME OF THE ACTIVITIES.

(D) HOSPITAL MANAGEMENT - CONCERN WAS RAISED OVER THE PROPOSED PROJECT'S HEAVY EMPHASIS ON TECHNICAL ASSISTANCE AND DEEMPHASIS ON TRAINING. IN LIGHT OF PREVIOUS DIFFICULTIES IN PROVIDING TECHNICAL ASSISTANCE TO THE MINISTRY OF HEALTH UNDER THE CURRENT PROJECT, THE MISSION WAS ENCOURAGED TO HIGHLIGHT TRAINING NEEDS OF THE PROJECT, PARTICULARLY IN THOSE AREAS WHICH WILL POSITIVELY IMPACT ON EFFICIENT OPERATION OF HEALTH CARE SYSTEM, E.G., HOSPITAL ADMINISTRATORS.

4. THE FOLLOWING PROJECT ISSUES WERE DISCUSSED AT THE DAEC REVIEW:

(A) PROJECT DESIGN THE MISSION SHOULD CAREFULLY REVIEW PROJECT STRUCTURE AND JUSTIFY REASONS FOR COMBINING WHAT APPEARS TO BE TWO PROJECTS UNDER ONE: AS OUTLINED IN THE PID, LINKAGE BETWEEN THE TWO COMPONENTS OF THE PROJECT IS UNCLEAR. THE AIDS/STD COMPONENT IS A

STRAIGHT FORWARD PROJECT WITH DIFFERENT FUNCTIONAL EMPHASIS FROM THE HEALTH CARE FINANCING COMPONENT, AND THE TWO COMPONENTS WILL USE DIFFERENT IMPLEMENTING UNITS. COMBINING BOTH ACTIVITIES INTO ONE PROJECT COULD MAKE IMPLEMENTATION MORE DIFFICULT AND STAFF INTENSIVE BECAUSE OF THE CONTINUING NEED TO ADDRESS THE COMPONENTS IN DIFFERENT PHS, SORT OUT ACCOMPLISHMENTS AND JUDGE PROGRESS ON EACH COMPONENT, AND IN THE FUTURE DEAL WITH CONTINUED NEEDS IN DIFFERENT WAYS. IF, DURING TECHNICAL ANALYSIS AND PROJECT DEVELOPMENT, THE MISSION BELIEVES THAT THERE ARE GOOD REASONS FOR COMBINING THE TWO ACTIVITIES UNDER ONE PROJECT, THE PROJECT PAPER SHOULD CLEARLY DEMONSTRATE THE STRATEGIC RELATIONSHIP BETWEEN THE TWO COMPONENTS AND THE IMPLEMENTATION BENEFITS OF LINKAGE, INCLUDING POLICY DIALOGUE.

IF INSTEAD, USAID DECIDES TO PREPARE SEPARATE PROJECTS, THE PID THAT WAS SUBMITTED CAN SERVE AS THE PID FOR BOTH PROJECTS AND THIS CABLE PROVIDES BUREAU CONCURRENCE WITH MISSION DELEGATION TO APPROVE THE PROJECT PAPERS AND AUTHORIZE THE PROJECTS. USAID MUST, HOWEVER, NOTIFY THE BUREAU BY CABLE IF IT PLANS TO APPROVE SEPARATE PROJECTS.

(B) FUNDING LEVELS - BECAUSE OF UNCERTAINTIES ABOUT RESOURCE AVAILABILITY, THE PROJECT SHOULD BE STRUCTURED TO TAKE INTO ACCOUNT THE POSSIBLE NEED TO PHASE FUNDING. TO ENSURE THAT THE BASIC OBJECTIVES OF THE PROJECT ARE MET AT REDUCED FUNDING LEVELS, THE PP SHOULD: (1) CLEARLY IDENTIFY KEY SUBCOMPONENTS IN THE PROJECT WHICH COULD BE PHASED IN AND ARE ESSENTIAL TO

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ANNEX B
PID APPROVAL CABLE

Response to 4 (C) - Beneficiaries:

The Social Soundness Analysis addresses concerns regarding beneficiaries. The Project's Policy Framework component will address the need to facilitate the proper policy environment in order to achieve the Project's objectives.

Response to 4 (D) - PSEIF:

This is not applicable since the final Project does not include the PSEIF.

ACHIEVE PROJECT OBJECTIVES AT CRITICAL FUNDING JUNCTURES, AND (2) MINIMIZE LONG TERM COMMITMENTS, E.G., LONG TERM ADVISORS/CONSULTANTS.

(C) BENEFICIARIES - THE PP SHOULD INCLUDE A DETAILED ANALYSIS OF WHO THE BENEFICIARIES ARE AND HOW THEY WILL BENEFIT FROM THE PROJECT. ADDITIONALLY, THE POLICY ENVIRONMENT SHOULD BE ANALYZED TO ENSURE THAT THE PROJECT TAKES INTO ACCOUNT ANY INTERVENTION IN THIS AREA REQUIRED TO ENSURE THE PROJECT ACHIEVES ITS OBJECTIVES. THE ANALYSIS SHOULD SPECIFICALLY EXAMINE HOW THE POPULATION SERVED BY PRIVATE FACILITIES COULD BE BROADENED TO INCLUDE LOWER INCOME GROUPS. THE ANALYSIS SHOULD ALSO INCLUDE THE RESULTS OF FURTHER EXAMINATION OF THE WILLINGNESS TO PAY FOR SERVICES ISSUED.

(D) PSEIF: NEED FOR FINANCING - THIS COMPONENT OF THE PROJECT OBVIOUSLY WILL REQUIRE EXTENSIVE ANALYTICAL WORK

PRIOR TO ITS INITIATION, INCLUDING CONFIRMATION THAT CREDIT IS A SIGNIFICANT CONSTRAINT FOR WHICH A UNIQUE AND DISCRETE NEW CREDIT SYSTEM IS REQUIRED. IN ADDITION, SOME OF THE ANALYSIS REQUIRED TO DESIGN THE CREDIT FUND APPEARS TO BE INCLUDED AS AN ELEMENT OF THE PROJECT ITSELF. FOR EXAMPLE, THE SIZE OF THE FUND TO BE AUTHORIZED IS ITSELF A MAJOR ISSUE BEEN VIEWED AGAINST THE TIGHT MORTGAGE SITUATION DISCUSSED IN PARA 4(B) ABOVE.

GIVEN ISSUES OF POTENTIAL POLICY CONCERN (INTEREST RATES, INSTITUTIONALIZATION OF A DISCRETE FUND, CRITERIA FOR QUALIFICATION AND PARTICIPATION OF RECIPIENTS, VALIDITY OF THE ASSUMPTION THAT CREDIT IS A KEY CONSTRAINT IN THE SECTOR), THE MISSION IS REQUESTED TO SUBMIT FOR AID/V REVIEW A DESCRIPTION OF THE FINAL DESIGN OF THE CREDIT COMPONENT PRIOR TO THE AUTHORIZATION OF THE FUND. THE DESCRIPTION SHOULD INCLUDE INFORMATION ON FUND STRUCTURE (ELIGIBILITY CRITERIA, INTEREST RATES, INSTITUTIONAL ARRANGEMENTS, MISSION INVOLVEMENT IN IMPLEMENTATION/SUBLOAN APPROVAL)

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ANNEX B
PID APPROVAL CASE

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded with Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT? Yes. Country Checklist completed with FY 89 PAAD 11/88.
Yes:

A. GENERAL CRITERIA FOR PROJECT

1. FY 1989 Appropriations Act Sec. 523; FAA Sec. 634A. If money is sought to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified?
2. FAA Sec. 611(a)(1). Prior to an obligation in excess of \$500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?
3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

Yes. LAC/CAR advised
CN sent on July 10, 1989

Yes.

A component of the Project will assist the GOJ in drafting new health care legislation. Appropriate legal drafting experts will be employed who will work directly with the Attorney General's office to prepare and assist in the adoption of revised statutes. See PP p. 15.

4. FAA Sec. 611(b); FY 1989 Appropriations Act Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)
5. FAA Sec. 611(a). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.
7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

N/A

N/A

No; N/A

The improved MOH & Private Sector capability to implement & plan health related activities will indirectly contribute to the listed goals.

All such effects would be indirect except insofar as U.S. private firms will provide TA or commodities under the Project.

STATUTORY CHECKLIST

9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

The GOJ is contributing over 25% of the total cost of the Project in local currency or in kind.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

The U.S. does not own any Jamaican currency.

11. FY 1989 Appropriations Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

N/A

12. FY 1989 Appropriations Act Sec. 549. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

N/A

13. FAA Sec. 119(g)(4)-(6) & (10). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other

- (a) No;
- (b) No;
- (c) No;
- (d) No

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- wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?
14. FAA Sec. 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? N/A.
15. FY 1989 Appropriations Act. If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? N/A.
16. FY 1989 Appropriations Act Sec. 538. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.? N/A.
17. FY 1989 Appropriations Act Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has prior approval of the Appropriations Committees of Congress been obtained? N/A.
18. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision). N/A.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FY 1989 Appropriations Act Sec. 548
(as interpreted by conference report
for original enactment). If
assistance is for agricultural
development activities (specifically,
any testing or breeding feasibility
study, variety improvement or
introduction, consultancy,
publication, conference, or
training), are such activities (a)
specifically and principally designed
to increase agricultural exports by
the host country to a country other
than the United States, where the
export would lead to direct
competition in that third country
with exports of a similar commodity
grown or produced in the United
States, and can the activities
reasonably be expected to cause
substantial injury to U.S. exporters
of a similar agricultural commodity;
or (b) in support of research that is
intended primarily to benefit U.S.
producers?

N/A

b. FAA Secs. 102(b), 111, 113, 281(a).
Describe extent to which activity
will (a) effectively involve the poor
in development by extending access to
economy at local level, increasing
labor-intensive production and the
use of appropriate technology,
dispersing investment from cities to
small towns and rural areas, and
insuring wide participation of the
poor in the benefits of development
on a sustained basis, using
appropriate U.S. institutions;
(b) help develop cooperatives,
especially by technical assistance,
to assist rural and urban poor to
help themselves toward a better life,
and otherwise encourage democratic
private and local governmental

By improving health status, the
Project will effectively
increase the capability of the
poor and women to participate
in the national economy.

institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

- c. FAA Secs. 103, 103A, 104, 105, 106, 120-21; FY 1989 Appropriations Act (Development Fund for Africa). Does the project fit the criteria for the source of funds (functional account) being used? Yes.

- d. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? Technology selected is based on extensive project analysis.

- e. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)? Jamaica is contributing over 25% of total project costs.

- f. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority? Yes.

g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.

Project was jointly developed by AID and MOH and will provide inputs to increase capacity of MOH. A majority of the planned T.A. will be provided by Jamaicans.

h. FY 1989 Appropriations Act Sec. 536. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?

No.

Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?

No.

Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

No.

i. FY 1989 Appropriations Act. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization?

No.

If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services?

N/A.

j. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes.

k. FY 1989 Appropriations Act. What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

The majority of the AID Direct contracts will be through buy-ins to existing competitively awarded contracts.

l. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been degraded by helping to increase

Yes.

N/A

production on lands already cleared or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) utilize the resources and abilities of all relevant U.S. government agencies?

- m. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity? N/A.

- n. FAA Sec. 118(c)(14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas?

- o. FAA Sec. 118(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; or (d) the construction of dams or other water control structures which flood relatively undegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

- p. FY 1989 Appropriations Act. If assistance will come from the Sub-Saharan Africa DA account, is it (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) being provided in accordance with the policies contained in section 102 of the FAA;

No.

(a) - (d) No.

N/A.

(c) being provided, when consistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (d) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups; (e) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

9. FY 1989 Appropriations Act Sec. 515.
If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same general region as originally obligated, and have the Appropriations Committees of both Houses of Congress been properly notified?

N/A.

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded with Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT? Yes. Country Checklist completed with FY 89 PAAD 11/88.
Yes:

A. GENERAL CRITERIA FOR PROJECT

1. FY 1989 Appropriations Act Sec. 523; FAA Sec. 634A. If money is sought to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified?
2. FAA Sec. 611(a)(1). Prior to an obligation in excess of \$500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?
3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

Yes. LAC/CAR advised
CN sent on July 10, 1989

Yes.

A component of the Project will assist the GOJ in drafting new health care legislation. Appropriate legal drafting experts will be employed who will work directly with the Attorney General's office to prepare and assist in the adoption of revised statutes. See PP p. 15.

FAA Sec. 611(b); FY 1989 Appropriations Act Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)

N/A

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?

N/A

6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

No; N/A

7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to:
(a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

The improved MOH & Private Sector capability to implement & plan health related activities will indirectly contribute to the listed goals.

8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

All such effects would be indirect except insofar as U.S. private firms will provide TA or commodities under the Project.

- 9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars. The GOJ is contributing over 25% of the total cost of the Project in local currency or in kind.

- 10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? The U.S. does not own any Jamaican currency.

- 11. FY 1989 Appropriations Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A

- 12. FY 1989 Appropriations Act Sec. 549. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel? N/A

- 13. FAA Sec. 119(g)(4)-(6) & (10). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other (a) No;
(b) No;
(c) No;
(d) No

wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

14. FAA Sec. 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)?
N/A.
15. FY 1989 Appropriations Act. If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?
N/A.
16. FY 1989 Appropriations Act Sec. 538. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?
N/A.
17. FY 1989 Appropriations Act Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has prior approval of the Appropriations Committees of Congress been obtained?
N/A.
18. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).
N/A.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FY 1989 Appropriations Act Sec. 548
(as interpreted by conference report
for original enactment). If
assistance is for agricultural
development activities (specifically,
any testing or breeding feasibility
study, variety improvement or
introduction, consultancy,
publication, conference, or
training), are such activities (a)
specifically and principally designed
to increase agricultural exports by
the host country to a country other
than the United States, where the
export would lead to direct
competition in that third country
with exports of a similar commodity
grown or produced in the United
States, and can the activities
reasonably be expected to cause
substantial injury to U.S. exporters
of a similar agricultural commodity;
or (b) in support of research that is
intended primarily to benefit U.S.
producers?

N/A

b. FAA Secs. 102(b), 111, 113, 281(a).
Describe extent to which activity
will (a) effectively involve the poor
in development by extending access to
economy at local level, increasing
labor-intensive production and the
use of appropriate technology,
dispersing investment from cities to
small towns and rural areas, and
insuring wide participation of the
poor in the benefits of development
on a sustained basis, using
appropriate U.S. institutions;
(b) help develop cooperatives,
especially by technical assistance,
to assist rural and urban poor to
help themselves toward a better life,
and otherwise encourage democratic
private and local governmental

By improving health status, th
Project will effectively
increase the capability of the
poor and women to participate
in the national economy.

80x

institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

c. FAA Secs. 103, 103A, 104, 105, 106, 120-21; FY 1989 Appropriations Act (Development Fund for Africa). Does the project fit the criteria for the source of funds (functional account) being used?

Yes.

d. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

Technology selected is based on extensive project analysis.

e. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

Jamaica is contributing over 25% of total project costs.

f. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

Yes.

g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.

Project was jointly developed by AID and MOH and will provide inputs to increase capacity of MOH. A majority of the planned T.A. will be provided by Jamaicans.

h. FY 1989 Appropriations Act Sec. 536. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?

No.

Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?

No.

Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

No.

i. FY 1989 Appropriations Act. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization?

No.

If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services?

N/A.

FAA Sec. 601(a). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes.

k. FY 1989 Appropriations Act. What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

The majority of the AID Direct contracts will be through buy-ins to existing competitively awarded contracts.

l. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been degraded by helping to increase

Yes.

N/A

production on lands already cleared or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) utilize the resources and abilities of all relevant U.S. government agencies?

- m. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity? N/A.

n. FAA Sec. 118(c)(14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas?

No.

(a) - (d) No.

o. FAA Sec. 118(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; or (d) the construction of dams or other water control structures which flood relatively undegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

p. FY 1989 Appropriations Act. If assistance will come from the Sub-Saharan Africa DA account, is it (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) being provided in accordance with the policies contained in section 102 of the FAA;

N/A.

8

(c) being provided, when consistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (d) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups; (e) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

86X

9. FY 1989 Appropriations Act Sec. 515.
If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same general region as originally obligated, and have the Appropriations Committees of both Houses of Congress been properly notified?

N/A

ANNEX D.1. TECHNICAL ANALYSIS - PUBLIC SECTOR*

I. Overview of the Sector

This section will present an up-to-date situational analysis of the sector in seven key areas: role of the public sector, policies, the institutional framework, facilities, range of services, outputs, expenditure and cost recovery. Each topic is discussed in the respective subsections which follows:

A. Role of the Public Sector

The Jamaican public sector plays a very significant role in all aspects of health: primary and secondary health care services, financing of health care services, training of health personnel and policies.

- Based on percentage of beds operated, the Jamaican public sector is playing the most significant role in health care services in Jamaica.
- An estimated 68% of expenditure on health services comes from the public sector.
- All of the local nursing schools and medical training facilities are financed by the public sector.

Table 1 and Exhibit 1 illustrate the extent of the Jamaican public sector involvement in health care services.

TABLE 1
 JAMAICAN PUBLIC SECTOR HEALTH CARE: COMPARATIVE LEVEL
 OF PUBLIC SECTOR ROLE BASED ON PERCENTAGE
 OF HOSPITAL BEDS OPERATED

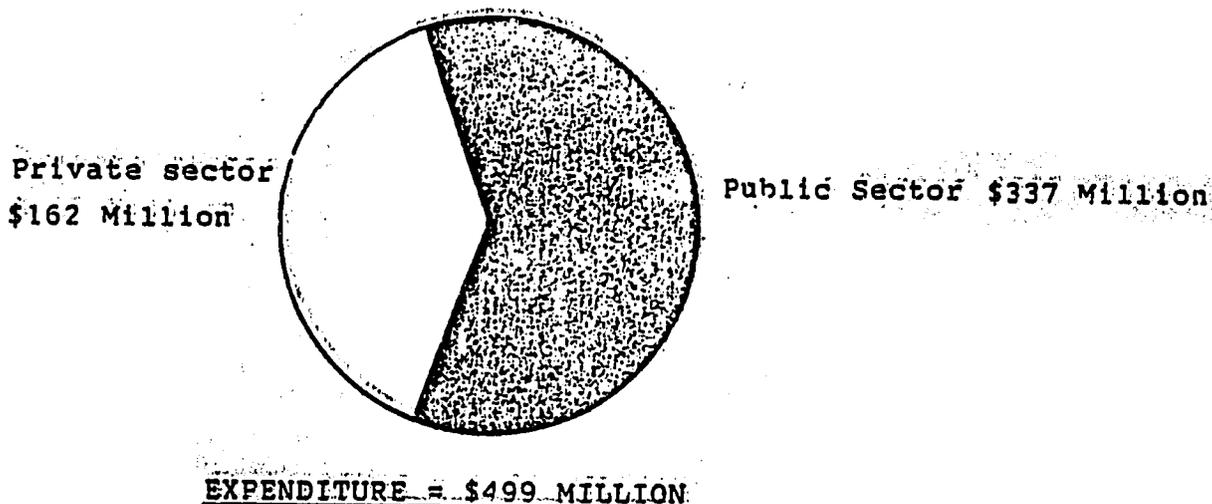
REGION/COUNTRY	Percentage of Hospital Beds	
	PUBLIC SECTOR	PRIVATE SECTOR
Latin America	54.9	45.1
Brazil	24.3	75.7
Central America	91.9	8.1
Medico	75.0	25.0
Commonwealth Caribbean Area	93.3	6.7
North America	47.8	52.2
Jamaica	92.6	7.4

Source: PAHO/WHO Hospital Restoration Project Jamaica, August 1987 Table 4.3.2

* This technical analysis is drawn from: "Review of the Jamaican Public Sector Health Services and the Health Insurance Industry." Trevor Hamilton and Associates. March 1989.

EXHIBIT 1-1

JAMAICA: ESTIMATED EXPENDITURE ON HEALTH CARE IN
\$ MILLION 1986 - THE PUBLIC SECTOR VS THE PRIVATE



Source: Management Analysis of Medical Associates Report
Page Vii-4, by Trevor Hamilton and Associates
September 1987.

The driving forces behind Jamaica's significant public sector role are:

- It has always been government's policy to make health care services a free service.
- The private sector has limited capacity to undertake especially complex health care cases.
- Health care services are less profitable than most private investment opportunities in Jamaica.

B. Policies

The Governments' policy is to promote private-public sector collaboration in the development and delivery of adequate health services. The immediate goals are:

- . To improve primary health care
 - easier accessibility to the population
 - more effective services
- . Increase the efficiency of secondary and tertiary levels of care.

Government is anxious to mobilize private sector management and financial services into the sector to reverse the trend of deterioration in the services, caused mainly by severe financial constraints over the past 5 years. The strategies government intends to implement to mobilize private sector resource support and improve efficiency include:

- . Execution of a fee for services policy on the basis of ability to pay.
- . Divestment of the operations of certain services to private sector to improve efficiency and subsequently savings in operating cost.
- . Promotion of health insurance schemes to improve the affordability to pay for health care services.
- . Rationalization of the services provided in the primary and secondary care facilities to allow for maximum efficiency.

C. Institutional Framework

Public sector health care services are planned, coordinated and monitored by the Ministry of Health through its network of primary health care clinics, secondary and tertiary hospitals, island wide and centralized services facilities such as the maintenance unit, island medical stores, and blood bank. Exhibit 11-1 which follows illustrates the structure of the Ministry of Health.

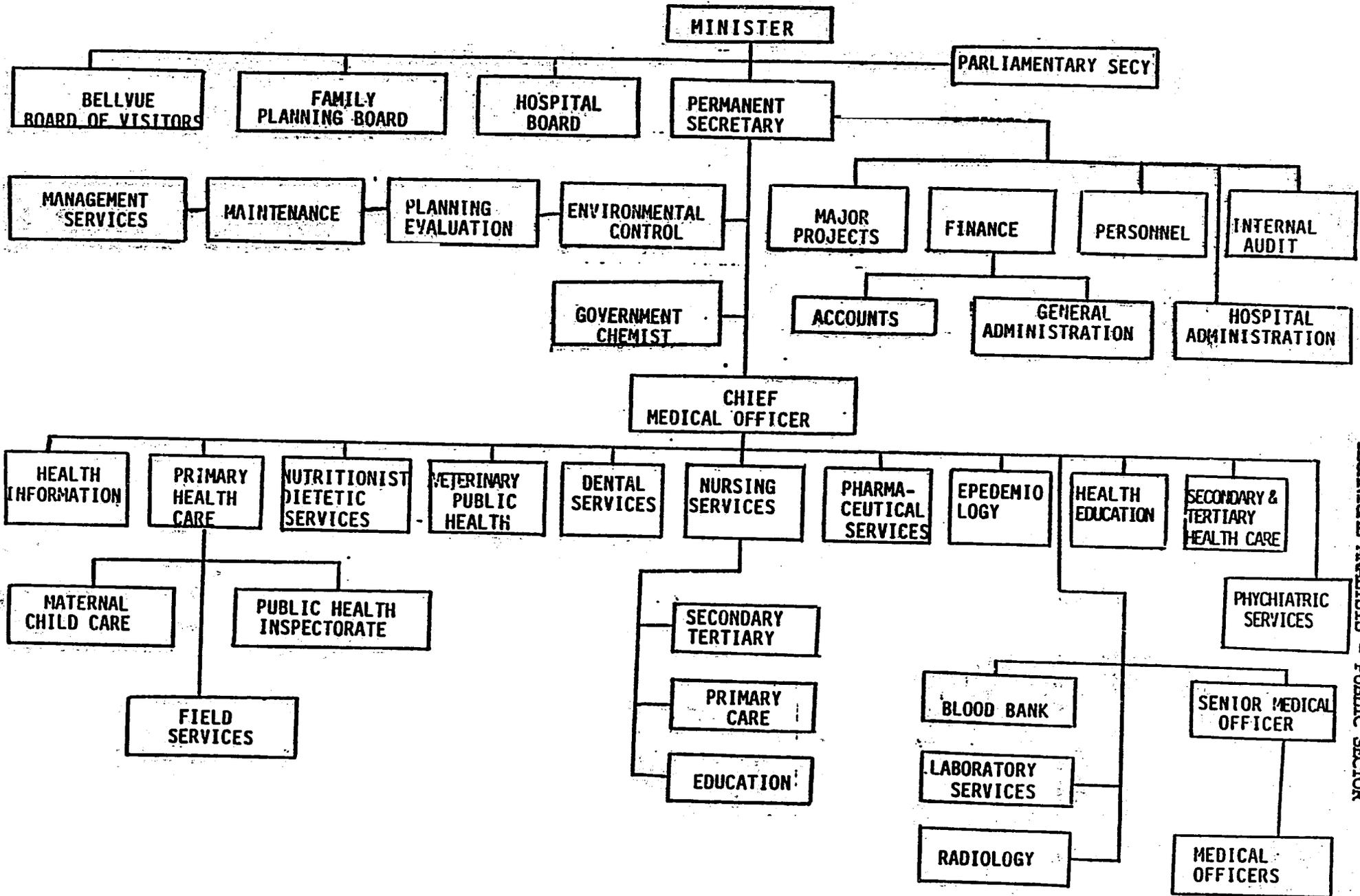
It delivers its private health care through 5 types of clinics.

- Type - I which provides mostly home visits. This type of clinic serves a population of 4,000 - 5,000. The key personnel is the midwife.
- Type - II which provides curative, preventive and promotive services is usually located in population clusters of 10,000 - 12,000 persons. The core staff comprises public health nurse, public health inspector, a visiting medical doctor, dentist and a registered nurse.
- Type - III provides curative and preventive care at a more technical level. The core personnel usually comprise doctor, a dentist, and a nurse practitioner. They are usually located in the main townships or parish centres.
- Type - IV is an extension of Type III which concentrates on more sophisticated services.
- Type - V provide specialized services in dental care, nursing care, and medicine.

Exhibit 2 is a composite organizational chart for the most sophisticated primary health care centre.

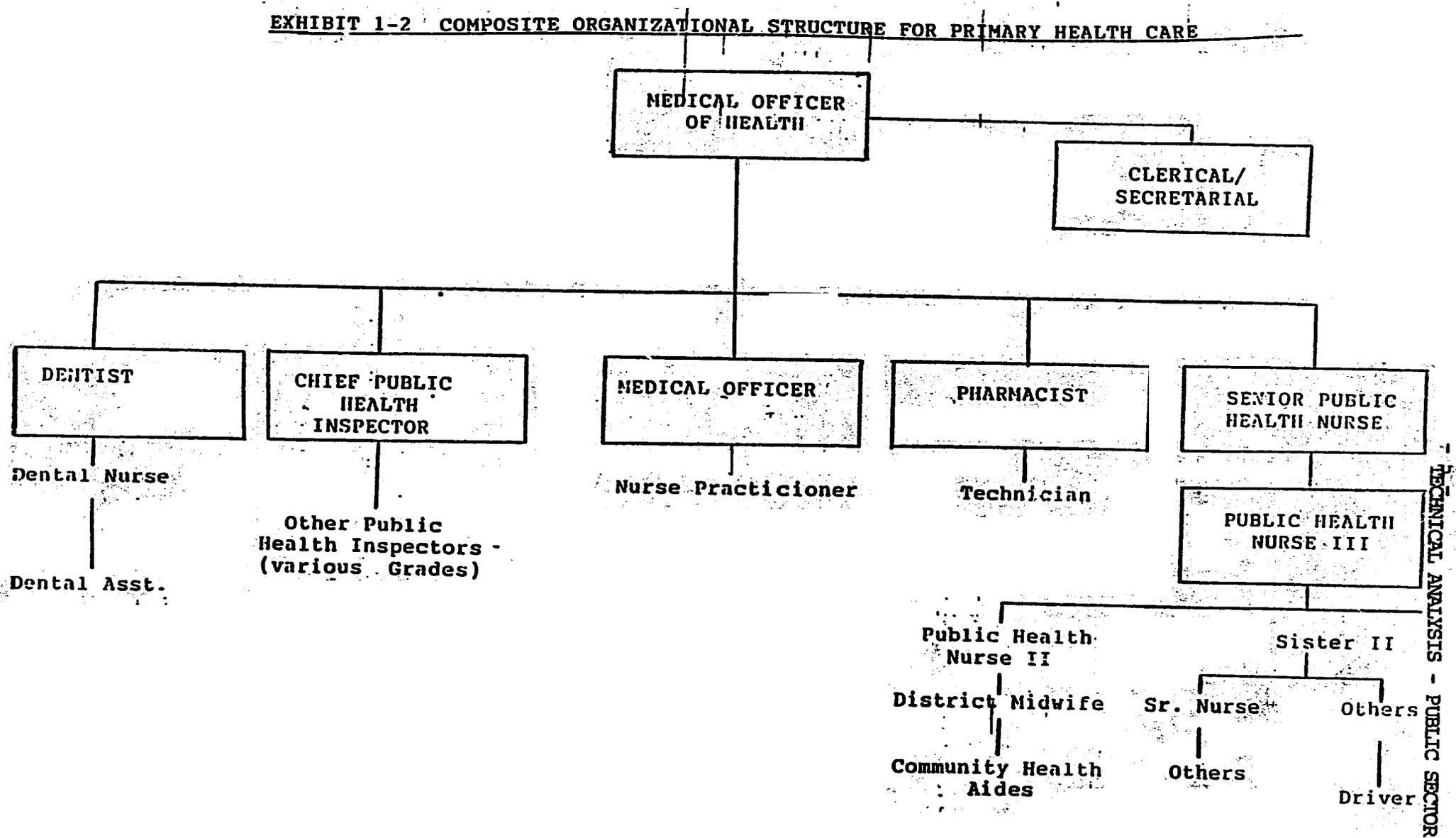
EXHIBIT 1-1

MINISTRY OF HEALTH ORGANIZATIONAL CHART



TECHNICAL ANALYSIS - PUBLIC SECTOR ANNEX D.1

EXHIBIT 1-2 COMPOSITE ORGANIZATIONAL STRUCTURE FOR PRIMARY HEALTH CARE



TECHNICAL ANALYSIS - PUBLIC SECTOR

-6-

Secondary and tertiary health care services are delivered through 4 categories of hospitals as follows:

- Type - C which is located at the parish centre, provides inpatient and outpatient care in medicine and MCH. It should come with a core staff comprising lab personnel, nurses, up to 3 medical doctors, and a surgeon on call.
- Type - B provides inpatient and outpatient care as well as some specialized services. This type of hospital is located in major urban centres.
- Type - A are located in Kingston and Montego Bay only. They provide the full range of secondary and tertiary care.
- Other Specialized Hospitals There are 4 such hospitals providing specialized care in 4 areas: obstetrics/gynaecology, child health, psychiatry and chest diseases.

Only health care services enjoy effective positioning in the organizational structure. The critical inputs such as stores management, financial administration, maintenance, staff incentives which are required to enhance the cost effectiveness and quality of the services, do not enjoy prominence in the organization.

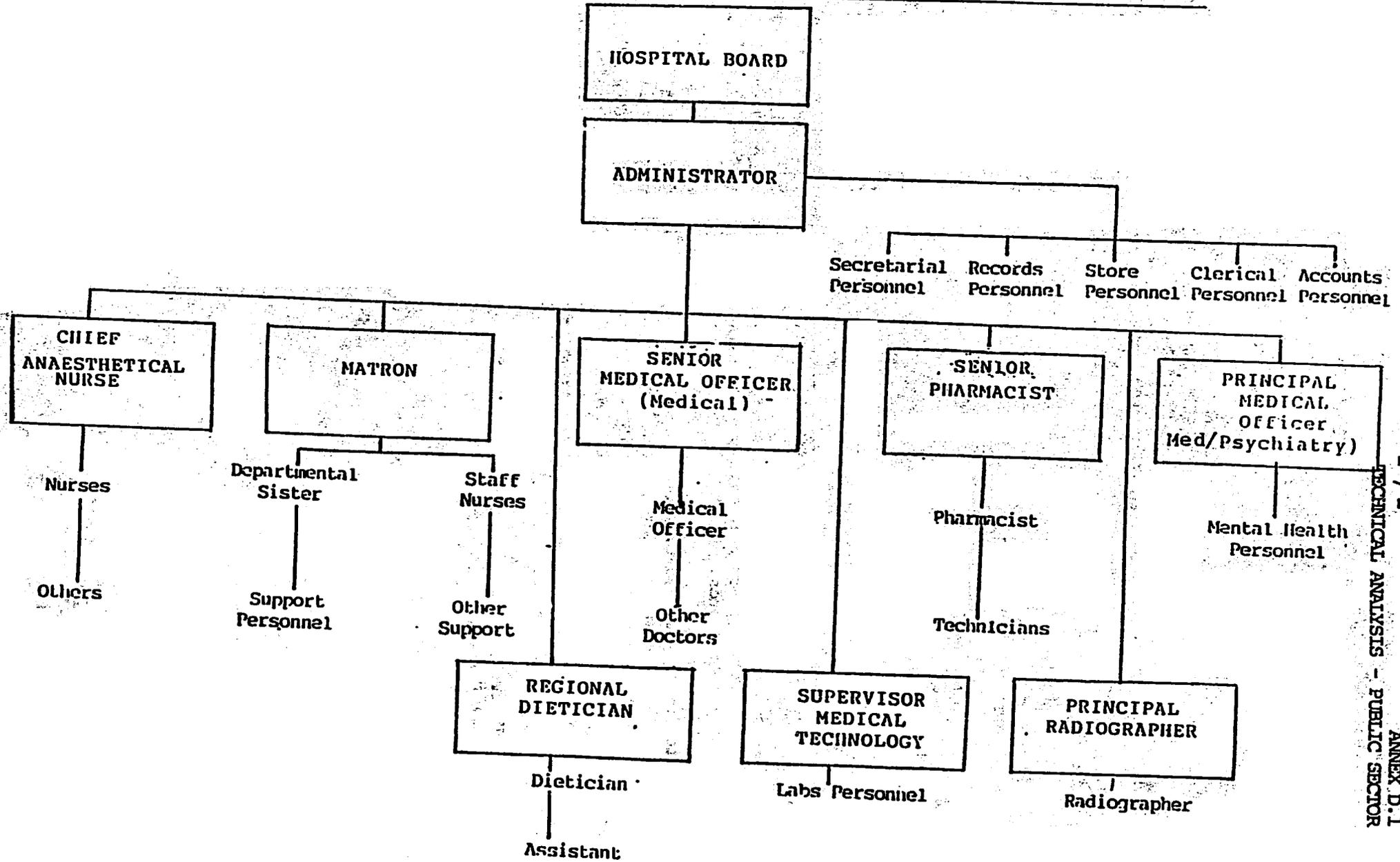
- Medical services supervisors who are concerned only with health care enjoy all the elite positions in the organizations. They are: chief anaesthetical nurse, matron, senior medical officer, senior pharmacist and principal medical officer form the core of the top management.
- Maintenance, stores, financial administration, catering and staff development are not in the hierarchy of the organizational structure.

Exhibit 3 which follows is a composite organization chart of a Jamaican hospital.

D. Facilities

The key supply facilities of the health care services are: the number of clinics, the number of hospitals and hospital beds and staffing. Primary health care is provided by 395 clinics with Type - I clinics accounting for 191 of 48%. Table 2 provides the details.

EXHIBIT 1-3 ASSESSED COMPOSITE JAMAICAN HOSPITAL ORGANIZATIONAL STRUCTURE



ANNEX D.1
TECHNICAL ANALYSIS - PUBLIC SECTOR

104

TABLE 2
 JAMAICA: NUMBER OF FUNCTIONAL PUBLIC SECTOR
 HEALTH CENTERS 1987

TYPE	NO.
I	191
II	87
III	78
IV	3
V	2
Family Planning	10
Dentist	
(A) School	18
(B) Mobile	6
TOTAL	395

Source: Economic and Social Survey 1987 Table 20.5

Public Secondary and tertiary health services are provided through 27 hospitals comprising 5,463 beds with psychiatry accounting for the single largest share of the beds. Exhibit 4 provides the details.

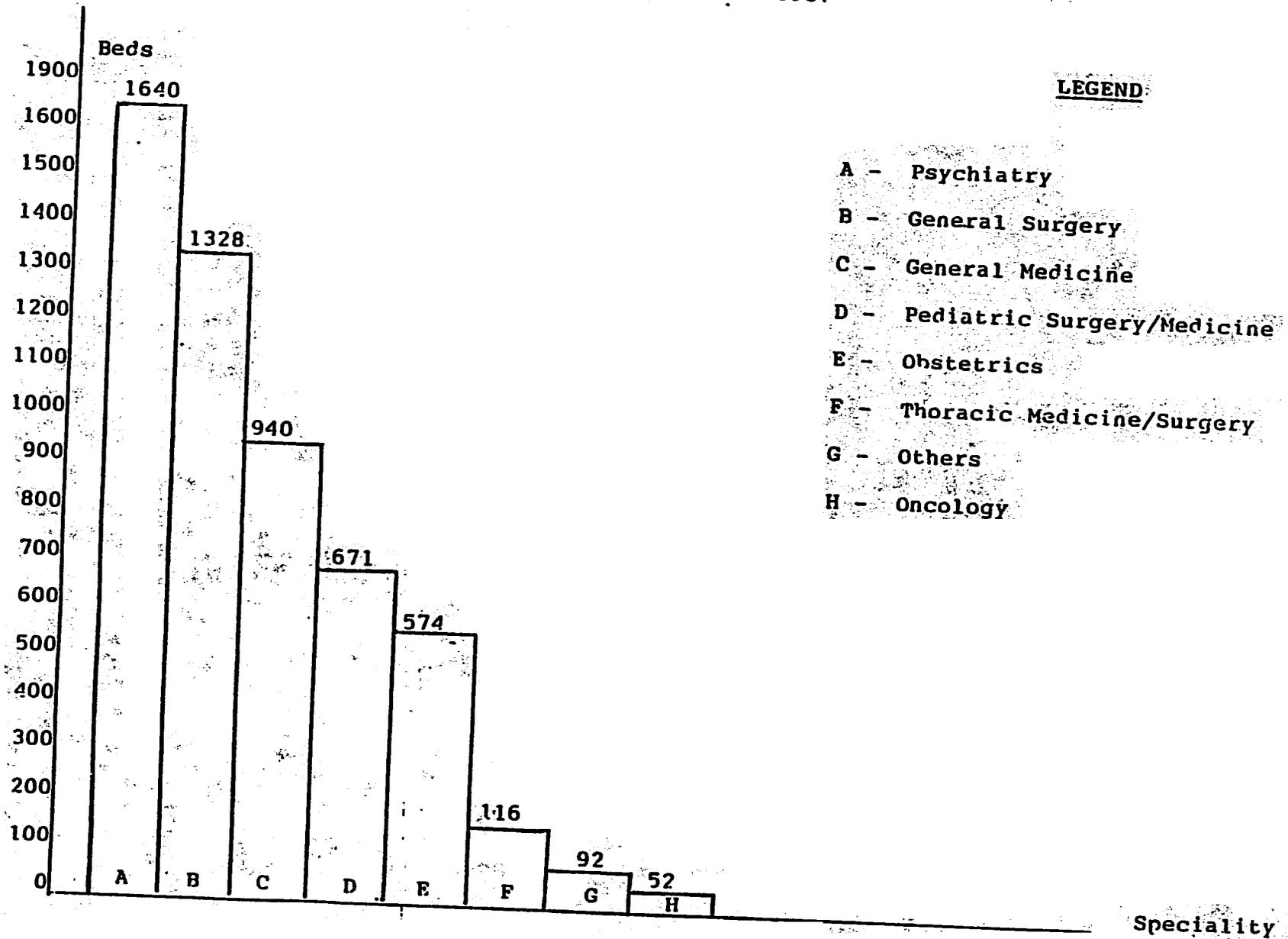
The service is very personnel intensive, with professional and technical assistance personnel accounting for the largest share. Nurses and public health inspectors are the largest categories of personnel as illustrated in Table 3.

TABLE 3
 JAMAICA: SITUATION REGARDING STAFFING 1987

Key Personnel	Number of Public Sector Staff
Registered Nurses	1,659
Doctors	330
Public Health Nurses	176
Midwives	470
Enrolled Assistant Nurses	846
Community Health Aids	509
Pharmacists	76
Pharmacy Technicians	121
Nutrition Group	57
Public Health Inspectors	343
Health Education Officers	26
Hospital Administrators	27
Therapeutic Radiographers	3
Diagnostic Radiographers	37
Physiotherapists	21
Occupational Therapists	1
Medical Technicians	92
EEG Technicians	2
Speech Therapist	1

Source: Health Information Unit, Ministry of Health

JAMAICAN PUBLIC SECTOR SECONDARY AND TERTIARY HEALTH CARE DISTRIBUTION OF HOSPITAL BEDS 1987



Source: Economic and Social Survey 1987 Table 20.16

E. Range of Services

The public sector provides a full range of services at the primary and secondary health care levels as follows:

Primary Health Care	Secondary Health Care
Antenatal	Casualty
Postnatal	Hospital inpatient
Child health	Hospital outpatient
Family planning	Major surgeries
Curative	Minor surgeries
Home visits	Pharmacy
Dental visits	Laboratory services
Nutritional assessments	Diagnostic X-rays etc.
	Physiotherapy

In 1987 5.5 million units (about 2.4 units per person) of these services were delivered with primary and secondary accounting for 2.7 million and 2.8 million respectively. Curative services are the largest category of primary health care. It accounts for 40% of all primary health care units of services delivered. Pharmacy which accounts for 44% of secondary health care is the largest of secondary health care services. Table 4 provides the details on the range of services and the respective levels of distribution.

TABLE 4
 UNITS OF HEALTH SERVICES PROVIDED BY
 THE PUBLIC SECTOR 1987

TYPE OF CARE	NUMBER OF UNITS NEAREST 000	% OF TOTAL
1. PRIMARY		
Antenatal	150	5.6
Post natal	72	2.6
Child health	404	15.1
Family Planning	349	12.7
Curative	1,063	39.7
Home Visits	247	9.2
Dental Visits	153	5.7
Nutritional Assessments	251	9.4
TOTAL	<u>2,679</u>	<u>100.0</u>

TABLE 4 (CONT'D)

TYPE OF CARE	NUMBER OF UNITS NEAREST 000	% OF TOTAL
2. SECONDARY		
Casualty (Emergency room)	495	17.5
Hospital inpatient	133	4.7
Hospital outpatient	454	16.1
Major surgeries	21	0.7
Minor surgeries	31	1.1
Pharmacy	1,239	43.9
Lab.	282	10.0
Diagnostic X-rays etc.		
(A) Inpatient	31	1.1
(B) Outpatient	112	4.0
Physiotherapy		
(A) Inpatients	10	0.4
(B) Outpatients	13	0.5
TOTAL	2,821	100.0

Source: Health Information Unit, Ministry of Health

F. Expenditure and Cost Recovery

During the period 1982/83 to 1986/87 the Government's priority focus was on the productive sector in order to develop the infrastructure required to enhance its export led economic growth program. Consequently, expenditure on the social sector was reduced very significantly. During the period the per capita expenditure on health care declined by approximately 4% annually in real terms. Table 5 provides the details.

TABLE 5
 JAMAICAN PUBLIC SECTOR HEALTH CARE PER CAPITA
 EXPENDITURE 1982/83 TO 1985/86

FISCAL YEAR	PER CAPITA IN REAL TERMS (J\$)
1982/83	75.6
1983/84	65.92
1984/85	54.66
1985/86	53.99
1986/87	62.12

Source: Economic and Social Survey of Jamaica 1987 Table 20.1B

98x

This reduction in per capita expenditure has generated general dissatisfaction in the quality of the health services especially in areas of: availability of drugs, the availability of medical personnel, and the physical facilities.

Even through their personnel are generally underpaid and there is a severe staff shortage, emoluments account for approximately 70% of the recurrent expenditure in health. Consequently, expenditure on drugs, other supplies and services have to be financed by a very limited amount of money. Table 6 illustrates the distribution of expenditure in hospitals.

TABLE 6
 JAMAICAN PUBLIC SECTOR HEALTH CARE: ESTIMATED DISTRIBUTION
 OF COST BY COST CENTERS IN HOSPITALS (IN J\$000) 1985

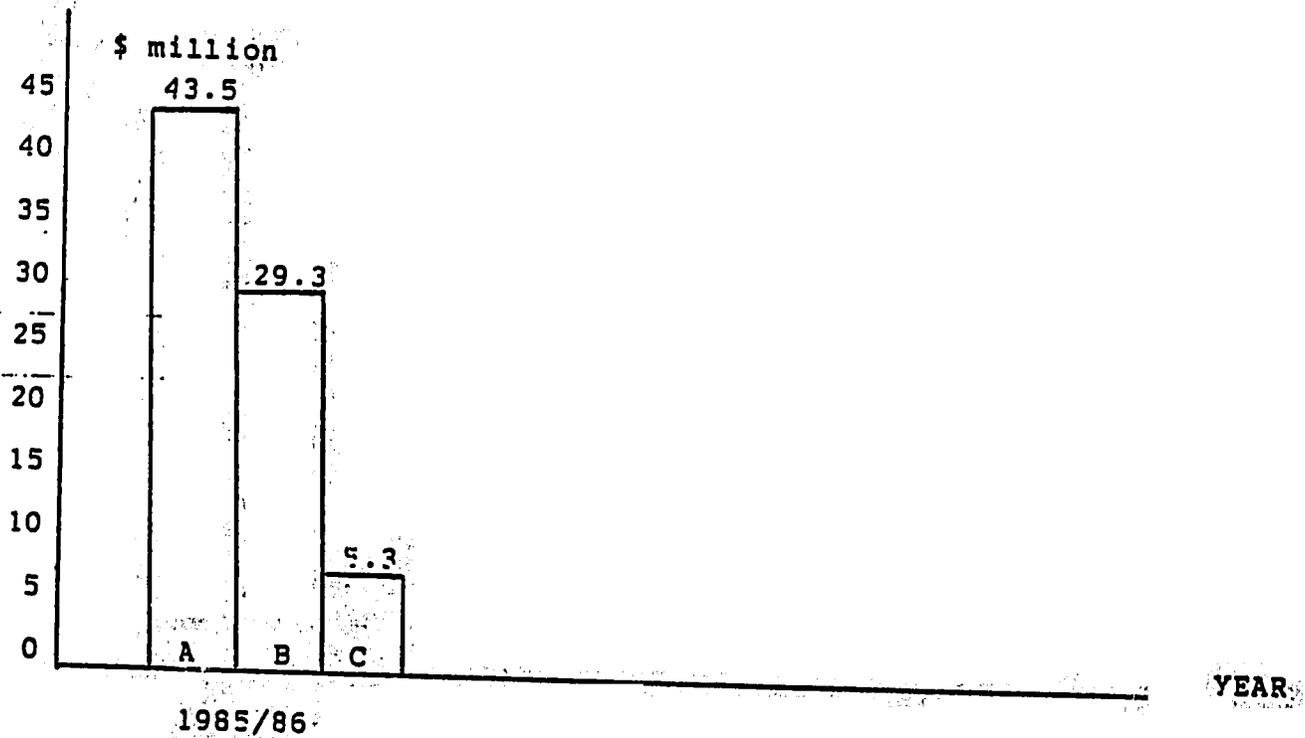
COST CENTERS	EMOLUMENTS	OTHER	TOTAL
Administration	3,384	1,003	4,392
Transport	1,419	4,488	5,907
Sanitation	4,640	0	4,640
Housekeeping	7,790	438	4,640
Maintenance	2,662	1,375	4,037
Utilities	0	6,412	5,412
Dietary	3,377	7,363	10,740
Linen	538	1,136	1,674
Medical Records	2,434	0	2,434
Pharmacy	4,081	11,587	15,668
X-ray	1,377	377	1,754
Physiotherapy	624	0	624
Laboratory	2,652	982	3,634
Operating Theatre	5,992	3,713	9,705
Inpatient	36,536	0	36,536
Outpatient	8,202	0	8,202
TOTAL	85,713	38,874	124,587

Source: PAHO/WHO Jamaica Hospital Restoration Project, 8/87, Table 2.6.29

The hospitals are operated under a partial cost recovery policy. Patients are therefore required to pay a flat fee for specific services if they can afford to pay. In fiscal year 1984/87 the maximum potential fee was J\$43.5 million with the maximum chargeable fee being about J\$29.3 million. Assuming about 33% of the population are medically indigent, the chargeable fee could be about J\$29.3 million however only J\$5.3 million has been collected as illustrated in Exhibit 1-5 which follows.

JAMAICAN PUBLIC SECTOR HEALTH CARE - POTENTIAL
AND COLLECTED FEES FOR SERVICES IN HOSPITALS 1986/87

TABLE 1-5



Source: Ministry of Health Information Unit.

LEGEND

- A --- Potential Chargeable
- B --- Potential Collectable
- C --- Actual Collections

The collection rate is very low mainly because of the following:

- The procedure for determining those with the ability to pay is weak.
- The collection system is ineffective.
- There are no penalties including denial of services, for avoidance of payment.
- Very little follow-up is executed.
- The organizational arrangements and staff assignment for collection are weak.

100X

Available data indicated that the compliance level is high in communities with the following administrative strengths.

- An officer is assigned to undertake collection.
- Health facilities in communities where there are many third parties responsible for paying the bills.

The Mandeville hospital for example, meets most of these favourable conditions. Consequently, the compliance rate is 70% as against 18% for the nation. Exhibits 6 and 7 schematically illustrate the administrative instruments used for clinics and hospitals respectively, the level of effectiveness and the driving forces behind the level of compliance.

II. TECHNICAL ANALYSIS OF THE SERVICE

The technical analysis is presented in the sub-sections: service standards, organization and management training efficiency and administration. They are discussed as follows:

A. Service Standards

Service Standards for professional services such as health care can be measured according to the ratio of key professionals to the population, as well as the turn-around time of patients at each facility, the hours of services available daily and the ease of accessibility to health care. The available data will allow us to perform an adequate level of indicative analysis of standards using some of these factors.

The availability of professional personnel required to enhance the quality of service in the sector is very poor, based on the Pan American Health Organization standards. The shortage of key personnel is most severe among dentists, medical doctors, registered nurses and assistant nurses.

- The desirable ratio for dentist is 1 per 2,857 population, while in actuality it is 1 per 43,537 or a shortfall of 93%.
- There should be 1 medical doctor per 910 persons but in actuality it is 1 per 7,127.

Table 7 provides the details.

TABLE 7
JAMAICA PUBLIC SECTOR HEALTH CARE:
INDICATIVE SERVICE STANDARDS (NATIONAL)

<u>SERVICE</u>	<u>DESIRABLE RATIO (PAHO STANDARDS)</u>	<u>ACTUAL RATIO</u>
Physicians : Population	1 : 910	1 : 7,124
Dentists : Population	1 : 2,857	1 : 43,537
Registered Nurses : Population	1 : 769	1 : 1,417
Assistant Nurses : Population	1 : 385	1 : 4,149

Source: Economic and Social Survey of Jamaica 1987 Table 20.19.

JAMAICAN PUBLIC SECTOR CLINICS:
COLLECTIONS PROCESS AND COMPLIANCE LEVEL

EXHIBIT 1-6

INSTRUMENTS USED

THREATS FROM PROFESSIONAL STAFF
OF DENIAL OF FUTURE CARE IF
PAYMENTS ARE NOT MADE

INEFFECTIVE

- Denial of care is unethical among health personnel
- No history of patients being denied services

ADMIN. ARRANGEMENTS

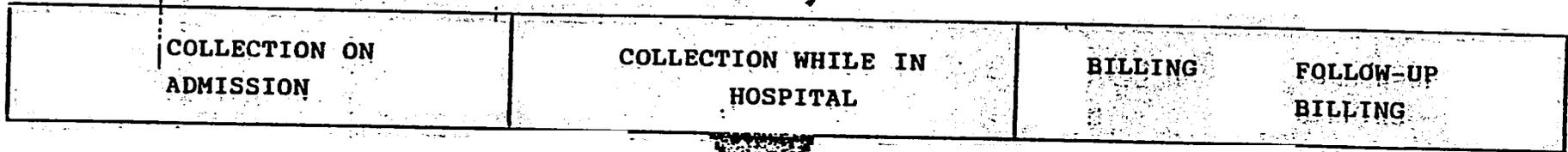
- . RECORDS OFFICER
- . CHIEF NURSE
- . PHARMACIST

DRIVING FORCES FOR LOW COMPLIANCE

- . ORGANIZATIONAL ARRANGEMENTS ARE AD HOC
- . EXCESSIVE PUBLIC PERCEPTION THAT SERVICE SHOULD BE FREE
- . NO INCENTIVES FOR STAFF TO COLLECT
- . CLINICS MAINLY USED BY PATIENTS WITHOUT THIRD PARTY PAYMENT SUPPORT

JAMAICAN PUBLIC SECTOR HOSPITALS: COLLECTIONS PROCESS, EFFECTIVENESS AND DRIVING FORCES

INSTRUMENTS



ORGANIZATIONAL ARRANGEMENTS

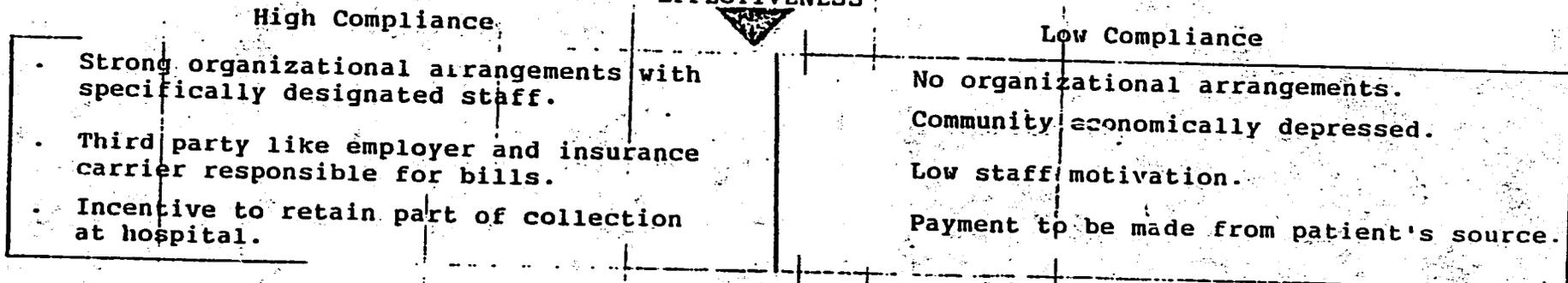
- . MEDICAL RECORDS OFFICER
- . ASSESSMENT OFFICER
- . CASHIER
- . NONE

COMPLIANCE

- . National 18.1
- . KPH 20.1
- . Mandeville 70%
- . May Pen 30%

DRIVING FORCES BEHIND

EFFECTIVENESS



The poor supply of these critical personnel has manifested itself in the following areas which generate poor standards.

- Patients sometimes wait for hours before being attended by a doctor or nurse.
- Doctors and nurses are required to work excessive hours. This could impair on their professional effectiveness.
- Pharmacy technicians and other professional frequently have to perform duties outside their area of competence.
- Patients frequently have to travel long distances in order to get attention because key personnel are not at the facilities designated for their communities.

The turn-around time for hospitalized patients is excessive primarily due to inefficient administration of services, especially at types B and C hospitals. It is also a desirable standard to have the availability of pharmacists for 24 hours; however, this standard has not been achieved. Table 8 provides some details of the level of services required in these areas as against present standards which the Ministry of Health hopes to achieve in the next 11 years.

TABLE 8
JAMAICAN PUBLIC SECTOR HEALTH CARE INDICATIVE SERVICE STANDARD
THEIR PRESENT SITUATIONS AND TARGET BY 2000

SERVICES	TYPE "A" HOSPITALS		TYPE "B" HOSPITALS		TYPE "C" HOSPITALS	
	CURRENT	TARGET	CURRENT	TARGET	CURRENT	TARGET
1. Length of stay for surgery (days)	9.5	9.5	7.1	6.0	5.9	5.0
2. Average length of stay for medical (days)	13.9	12.0	12.9	9.5	8.0	7.0
3. Average length of maternity stay (days)	4.4	3.5	3.1	2.5	1.6	1.6
4. Average length of stay for children	13.5	8.5	8.0	7.0	6.3	6.0
5. Occupancy rate (%)	83	85	96	85	79	75
6. Physician on duty or call 24 hours.	Yes	Yes	Yes	Yes	Yes	Yes
7. Nurse on duty or call 24 hrs.	Yes	Yes	Yes	Yes	Yes	Yes
8. X-ray and lab. 24 hrs.	Yes	Yes	Yes	Yes	Yes	Yes
9. Pharmacy on call 24 hrs.	No	Yes	No	Yes	Not Required	Not Required

1047

B. Organization and Management

Inadequate staffing, high attrition rates and relatively poor pay which are all intertwined are the key organizational issues affecting the public sector health care services.

Vacancies among key personnel range as high as 88% with pharmacists, nurses, diagnostic radiographers, and public nurses being the areas with the most severe shortages. The shortages occur mainly due to low pay, reduced training outputs and high rates of attrition. Most of those who quit the services leave to take up more attractive positions in the local private sector or higher paid posts in the USA. Table 9 provides the details on the staffing situation among key health personnel.

Professional health personnel are poorly paid in comparative and real terms. They receive salaries equivalent to 36% to 52% of those received by personnel in other positions requiring comparable training, experience and responsibilities. For example:

- A doctor receives 52% of the salary of a specialist engineer, a systems analyst or a financial controller even though the doctor's efforts, experience, training and scarcity are almost twice as much as that required by the engineer to do his job.
- An accountant, insurance sales person or executive secretary receives over twice as much as a nurse despite the fact that a nurse works longer hours, is in scarce supply, requires similar years of professional training and also has an enormous personal responsibility for the wellbeing of others while she is at work.
- A branch manager, sales supervisor or production supervisor earns over twice as much as a matron even though the matron requires more tertiary and specialized education, experience and works longer hours.
- A pharmacist graduating from the College of Arts Science and Technology like the electronics specialist, draughtsman earns less than half of the salary they are paid, even though he is in scarce supply and he has to work longer hours.

TABLE 9
JAMAICA: PUBLIC SECTOR HEALTH CARE STAFFING
SITUATION 1987

Type of Personnel	Organizational Requirements (Establishments)	Positions Filled	Vacancies	% Vacant
Doctors	432	326	106	25
Staff Nurse and Sister	2,025	1,490	535	26
Enrolled Assistant Nurses	1,120	836	284	25
Public Health Nurses	172	127	45	26
Midwives	520	N.A	N.A	
Nurse Practitioners	60	57	3	5
Dentists	78	63	15	19
Dental Aux. Nurses	153	145	8	5
Dental Assistants	149	132	17	11
Pharmacists	152	82	70	46
Diagnostic Radiographers	64	43	21	33
Therapeutic Radiographers	16	2	14	88
Nutritionists	11	4	7	64

Source: Health Information Unit, Ministry of Health.

TABLE 10
JAMAICAN PUBLIC HEALTH SECTOR:
ANALYSIS OF STAFFING SITUATION 1987

Selected Posts	Annual Attrition	Annual Training Output	Annual Training Requirements in Next 5 Years
Nurses - General	300+	57	450
Medical Doctors	22	65	108
Pharmacists	12	20	46
Radiographers (Diagnostic)	10	6	20
Physiotherapists	8	7	17
Medical Technologists	10	20	35
Public Health Inspectors	29	10	49
Nurse Anaesthetists	N/A	3	
Health Management	1	6	Maintain level

106r

-20-

The results of these comparative salary assessments were computed on the basis of 10 key factors used to determine the level of compensation among professional personnel. Those factors are:

- . Relative years of tertiary education.
- . Years of required experience.
- . Years of required post graduate or specialist education.
- . Level of assets to be controlled.
- . Level of job hazard.
- . Importance of the wellbeing of others.
- . Number of persons to supervise.
- . Relative scarcity of skills.
- . Weekly work load in excess of 40 hours.
- . Frequently of being on call for emergency duties.

Table 11 summarizes the comparative annual salaries of 5 categories of health personnel as against comparable personnel using the compensatory factors listed above. The five categories of personnel are: doctors, registered nurses, medical technologists, matrons, and pharmacists. Table 12 provides the detailed computation for each category of health personnel and its counterparts.

C. Training

This subsection focuses on two areas of training: the training infrastructure and capabilities, and present situation regarding the supply of training personnel.

Jamaica has the institutional facilities to train the basic professional skills in medicine, nursing, public health, pharmacology, medical technology and other areas. It can also provide training in a limited range of post graduate or specialized areas in medicine, surgery, obstetrics, gynaecology, and radiology.

It however has limited capacity for training in professional or specialized training in areas such as cardiology, dermatology, chest disease, neurosurgery, plastic surgery, paediatric surgery, nuclear medicine and psychiatry. These skills are developed by overseas institutions. Table 13 which follows, provides the details on the sources of training for key professional personnel in the Jamaican health services.

This enormous institutional capacity to develop the key skills in health care gives Jamaica a sound foundation for maintaining stability and improvement of health care services provided that appropriate conditions are introduced to encourage retention of staff.

TABLE I - 11 COMPARATIVE ANNUAL SALARIES OF HEALTH PERSONNEL

PERSONNEL	AVERAGE SALARY \$000	AVERAGE SALARY FOR NON-HEALTH PERSONNEL	NUMBER OF 'H' RATING ON COMPENSATING FACTORS	AVERAGE 'H' RATING ON COMPENSATING FACTORS FOR NON-HEALTH PERSONNEL	NUMBER OF 'H' RATING OF HEALTH PERSONNEL AS FACTOR OF NON-HEALTH PERSONNEL	AVERAGE SALARY OF HEALTH PERSONNEL AS FACTOR OF NON-HEALTH PERSONNEL AVERAGE SALARY
DOCTOR	70		6			
SPECIALIST ENGINEER	120		3		1.82	0.52
SYSTEMS SPECIALIST	130	135	3	3.3		
FINANCIAL CONTROLLER	155		4			
REGISTERED NURSE	20		5			
ACCOUNTANT	55		1		5.0	0.36
INSURANCE SALES PERSON	70	55	0	1		
EXECUTIVE SECY.	40		2			
MEDICAL TECHNOLOGIST	15		4			
COMPUTER PROGRAMMING	36		0		4.0	0.43
BANK SUPERVISOR	36	35	2	1		
OFFICE MANAGER	33		1			
MATRON	34		8			
PRODUCTION SUPERVISOR	58		3	2	4.0	0.47
SALES SUPERVISOR	52	73	0			
BRANCH BANK MANAGER	110		3			
PHARMACIST	26		3			
DRAUGHTSMAN	38		0		1.80	0.48
MACHINIST	58	54	3	1.67		
ELECTRONICS SPECIALIST	65		2			

Source: Table I - 12 of this report

JAMAICAN PUBLIC SECTOR HEALTH CARE: COMPARATIVE SALARIES OF KEY PERSONNEL

<u>DOCTORS</u>	<u>PERSONNEL</u>			
	<u>CONSULTANT DOCTOR</u>	<u>SPECIALIST ENGINEER</u>	<u>SYSTEMS SPECIALIST</u>	<u>FINANCIAL CONTROLLER</u>
Relative years of tertiary education.	H	M	M	H
Years of required experience.	M	H	H	H
Years of required post graduate or specialist education.	H	L	L	M
Level of assets to be controlled.	L	H	M	H
Level of job hazard.	M	H	L	L
Importance of the wellbeing of others.	H	M	L	L
Number of persons to supervise.	L	M	H	H
Relative scarcity of skill.	H	M	H	M
Weekly work load over 40 hours.	H	L	L	L
Frequency of being-on-call for emergency duties.	H	L	L	L

LEGEND

H - HIGH

M - MODERATE

L - LOW/MARGINAL

Source: Trevor Hamilton and Associates' Survey 1988

TABLE I - 12 (CONT'D)

JAMAICAN PUBLIC SECTOR HEALTH CARE: COMPARATIVE SALARIES OF KEY PERSONNEL - STAFF NURSES

<u>COMPENSATING FACTORS TO PERFORM JOB</u>	<u>REGISTERED NURSE</u>	<u>ACCOUNTANT</u>	<u>INSURANCE SALES PERSON</u>	<u>EXECUTIVE SECRETARY</u>
Relative years of Tertiary education.	M	M	L	L
Years of required experience.	L	M	L	H
Years of required post graduate/specialist Education.	L	L	L	L
Level of asset to be controlled.	L	H	L	M
Level of job hazard.	H	L	M	L
Importance of the well-being of others.	H	L	M	M
Number of persons to supervised.	L	M	L	L
Relative scarcity of skill.	H	M	L	M
Weekly work load over 40 hours.	H	L	M	H
Frequency of being on call for emergency duties.	H	L	L	L

LEGEND

H - HIGH

M - MODERATE

L - LOW/MARGINAL

Source: Trevor Hamilton and Associates' Survey 1988

JAMAICA PUBLIC SECTOR HEALTH CARE COMPARATIVE SALARIES OF KEY PERSONNEL - MEDICAL TECHNOLOGIST

<u>COMPENSATING FACTORS FOR PERFORMING THE JOB</u>	<u>MEDICAL TECHNOLOGIST</u>	<u>COMPUTER PROGRAMMER</u>	<u>BANK SUPERVISOR</u>	<u>OFFICE MANAGER</u>
Relative years of tertiary education.	M	M	L	L
Years of required experience.	M	M	M	M
Years of required post graduate/specialist education.	M	L	L	L
Level of assets to be controlled.	M	M	H	M
Level of job hazard.	M	L	L	L
Importance of the wellbeing of others	H	L	L	M
Number of persons to supervise.	L	L	H	H
Relative scarcity factor.	H	M	L	L
Weekly word load over 40 hours.	H	L	L	L
Frequency of being on call for emergency duties.	H	L	L	L

LEGEND

H - HIGH

M - MODERANTE

L - LOW/MARGINAL

Source: Trevor Hamilton and Associates' Survey 1988

TABLE I - 12 (CONT'D)

JAMAICAN PUBLIC SECTOR HEALTH CARE: COMPARATIVE SALARIES OF KEY PERSONNEL - MATRON

<u>COMPENSATING FACTORS FOR PERFORMING JOB</u>	<u>MATRON</u>	<u>PRODUCTION SUPERVISOR</u>	<u>SALES SUPERVISOR</u>	<u>BRANCH MANAGER FOR A BANK</u>
Relative years of tertiary Education.	H	M	L	M
Years of required experience.	H	M	M	H
Years of required post graduate on specialist education.	H	L	L	L
Level of assets to be controlled.	L	H	L	H
Level of job hazard.	M	H	L	L
Importance of the well being of others.	H	M	L	M
Number of persons supervised.	H	H	M	H
Relative scarcity of skill.	H	M	L	M
Weekly work load over 40 hours.	H	M	L	L
Frequency of being on call for emergency duties.	H	L	L	L

LEGEND

H - HIGH

M - MODERATE

L - LOW/MARGINAL

Source: Trevor Hamilton and Associates' Survey 1988

112x

TABLE 13
 JAMAICA PUBLIC SECTOR HEALTH CARE:
 SOURCES FOR BASIC PROFESSIONAL TRAINING OF PERSONNEL

SELECTED PROFESSION	JAMAICA	OVERSEAS
Medical Doctors	X	
Nurses - General	X	
Nurse Practitioner	X	
Nurse Public Health	X	
Pharmacists	X	
Pharmacist Technician	X	
Radiographers (Diagnostic)	X	
Physiotherapists	X	
Medical Technologist	X	
Public Health Inspectors	X	
Nurse Anaesthetists	X	
Health Management	X	

Source: Ministry of Health

TABLE 13 (CONT'D)
 SOURCES OF POST GRADUATE SPECIALIZED TRAINING

SELECTED PROFESSION	JAMAICA	OVERSEAS
<u>DOCTORS</u>		
Anaesthetics	X	
Cardiology		X
Dermatology		X
Chest Diseases		X
Adult Medicine	X	
Psychiatry	Limited	
Family Medicine	X	
Paediatric Medicine	Limited	
Public Health	X	
Dentistry		X
<u>SURGICAL</u>		
E.N.T.	X	
General	X	
Neurosurgical		X
Ophthalmic	X	
Orthopedic		X
Urological	X	
Cardio-thoracic Surgery		X
Plastic Surgery		X
Paediatric Surgery		X

TABLE 13 (CONT'D)
 SOURCES OF POST GRADUATE SPECIALIZED TRAINING

SELECTED PROFESSION	JAMAICA	OVERSEAS
<u>OBSTETRICS AND GYNAECOLOGY</u>		
Obstetrics and Gynaecology	x	
Neonatology		x
<u>RADIOLOGY</u>		
Diagnostic	x	
Therapeutic		x
Nuclear Medicine		x
<u>PATHOLOGY AND MICRO BIOLOGY</u>		
Pathology	x	
Immunology		x
Haematology	Limited	x
<u>NURSES</u>		
Public Health Nurses	x	
Post Basic Psychiatric Nursing	x	
Administration Course	x	
Certificate in Community Health	x	
Advanced Nursing (Education)	x	
Nurse Practitioner	x	
BSc in Nursing	x	
Midwifery	x	
Intensive Care Nursing	x	
Advanced Management	x	
Operating Theatre Technique	x	
Nursing Anaesthetist	x	

Source: Ministry of Health

Despite Jamaica's enormous capacity to supply a wide range of key health personnel, financial constraints, and modification of policy priorities have resulted in the reduction of numerous training programs. The programs experiencing severe reductions are:

- . The enrolled assistant nurses program
- . Nurse Practitioners
- . Community Health Aides
- . General Nurses
- . Dental nurses and assistants
- . Health management
- . Public health

The reduction of training programs and skills upgrading in these areas is poorly timed given the rapid attrition rate among health care personnel in the past 5 years.

There are also some areas where the facilities and financial support are adequate. However due to the relatively high admission standards required and the low levels of salaries associated with the positions, the schools are unable to recruit enough students to pursue the courses. Such areas of study are: pharmacology, physiotherapy, dietetics and nursing administration. Salaries will have to be significantly increased or the admission standard distinctly reduced to attract more students in these areas. The details of the situation in training are presented in Table 14 on the preceding page.

D. Efficiency

The focus of this topic is on the level of productive time health care professionals spend on the job, and the turn-around time for patients. Most health care personnel spend over 50% of their time in unproductivity or engaged in non-professionally related activities while they are on the job. Such activities include paperwork relating to patient record and undertaking other routine tasks. For example, the unproductive time at primary health care facilities as illustrated in Table 15 is as high as 81% for dentists. (Unproductive time is caused from high rate of absenteeism, no shows or lateness due to poor transportation services, professionals doing rudimentary work, and poor work organization.)

TABLE 15
 JAMAICAN PUBLIC SECTOR HEALTH CARE
 UNPRODUCTIVE TIME SPEND BY KEY PERSONNEL IN PRIMARY HEALTH CARE SERVICES

PERSONNEL	LEVEL OF UNPRODUCTIVE TIME (%)
Dentist	81
Dental Nurse	55
Medical Officer	54
Public Health Inspector	48
Registered Nurse	33
Nurse Practitioner	36

Source: PAHO/WHO Hospital Restoration Project (PRICOR STUDY) August 1987 2-83

Professional personnel spend a high percentage of their time unproductively or in routine activities because auxiliary staff are not performing their tasks effectively.

- many of them are untrained
- many require skills upgrading
- the level of absenteeism is very high

The turn-around time for patients is very high. For example, it takes 109 minutes at a composite clinic without drugs and 248 when drug service is involved.

- When no drug service is involved, an estimated 25 minutes of the 109 minutes of waiting time (23%) is spent on receiving services.
- When drug service is involved, an estimated 25 minutes of the 248 minutes (11%) is spent receiving services.

116X

TABLE I - 14

JAMAICAN PUBLIC HEALTH CARE: TRAINING REQUIREMENTS FOR
FOR KEY SKILLS AND SUPPLY SITUATION

PROFESSION OR MAIN TRAINING AREAS	INSTITUTION (S) PROVIDING SKILLS AND MODE OF TRAINING	OUTPUT CAPACITY AND SUPPLY SITUATION	KEY REASONS FOR CONSTRAINTS
Enrolled Assistant Nurses	Kingston School of Nursing - lectures - practical work	<ul style="list-style-type: none"> . Capacity adequate . Program suspended from time to time . Training program contracted while demand is growing . Annual output is about 25 graduates . Annual demand for graduates is caused by high attrition rate. 	<ul style="list-style-type: none"> . Under estimation of needs. . Reduced financial support. . Higher salaries in the private sector is responsible for high attrition rate.
Nursing Administrators	University of the West Indies - lectures - Practical work	<ul style="list-style-type: none"> . Program curtailed. 	<ul style="list-style-type: none"> . Inadequate financial support. . Severe staff shortage restricts staff leave to undertake training
Nurse Practitioners	Ministry of Health - 1 year course - prerequisite is attainment of sister or position or being a seasoned SRN.		

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TABLE I - 14 (CONT'D) JAMAICAN PUBLIC SECTOR HEALTH CARE: TRAINING REQUIREMENTS
FOR KEY SKILLS AND SUPPLY SITUATION

<u>PROFESSION OR MAIN TRAINING AREAS</u>	<u>INSTITUTION(S) PROVIDING SKILLS AND MODE OF TRAINING</u>	<u>OUTPUT CAPACITY AND SUPPLY SITUATION</u>	<u>KEY REASONS FOR CONSTRAINTS</u>
Pharmacy Technicians	Ministry of Health in collaboration with the College of Arts Science and Technology 1 year of practical oriented training.	<ul style="list-style-type: none"> • Suspended since 1985 • Present supply is adequate • Future short fall is likely - if suspended training continues. 	Withdrawal of government funding.
Nurse Anaesthetists	<ul style="list-style-type: none"> • Ministry of Health School of Nursing Anaesthesiology • 18 months duration <ul style="list-style-type: none"> - 12 months theory - 6 months practice. 	<ul style="list-style-type: none"> • Adequate capacity exists. • Annual demand for graduates is 16 	No major constraints
Community Health Aides	<ul style="list-style-type: none"> • University of the West Indies, Department of Social and Preventive Medicine. • Duration of training is 1 year <ul style="list-style-type: none"> - theory - practical 	<ul style="list-style-type: none"> • Suspended • Services no longer provided 	<ul style="list-style-type: none"> • Lack of financial support. • Government's policy to suspend this type of service.
Radiographers (Diagnostic)	<ul style="list-style-type: none"> • UWI <ul style="list-style-type: none"> - didactic - practical • Duration of training is 3 years. 	<ul style="list-style-type: none"> • Average annual output is 6 graduates. • Very limited training capacity • Demand for graduates is 15 per year. 	<ul style="list-style-type: none"> • Several shortage of teaching staff. • Inadequate training facilities.

TECHNICAL ANALYSIS - PUBLIC SECTOR

18/11

TABLE I - 14 (CONT'D) JAMAICAN PUBLIC SECTOR HEALTH CARE: TRAINING REQUIREMENTS FOR KEY SKILLS AND SUPPLY SITUATION

PROFESSION OR MAIN TRAINING AREAS	INSTITUTION(S) PROVIDING SKILLS AND MODE OF TRAINING	OUTPUT CAPACITY AND SUPPLY SITUATION	KEY REASONS FOR CONSTRAINTS
Therapeutic Radiographers	Training is overseas No facilities are in Jamaica.	<ul style="list-style-type: none"> . Annual demand for graduates is 3 . There is a major problem retaining graduates - migration of those who returned after training. 	<ul style="list-style-type: none"> Low salaries Poor working conditions.
Pharmacists	College of Arts Science and Technology, Jamaica <ul style="list-style-type: none"> - 3 years training comprising - theory - practice 	<ul style="list-style-type: none"> . Annual intake is 30 . Average annual output is 23 . Annual demand for graduates is 26 . The public sector is not able to retain graduates. 	<ul style="list-style-type: none"> . Low salaries - private sector salaries are much higher. - opportunities for self operated practice.

TABLE 1 - 14 (CONT'D) JAMAICAN PUBLIC SECTOR HEALTH CARE: TRAINING REQUIREMENTS
FOR KEY SKILLS AND SUPPLY SITUATION

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<u>PROFESSION OR MAIN TRAINING AREAS</u>	<u>INSTITUTION(S) PROVIDING SKILLS AND MODE OF TRAINING</u>	<u>OUTPUT CAPACITY AND SUPPLY SITUATION</u>	<u>KEY REASONS FOR CONSTRAINTS</u>
Physiotherapists	<ul style="list-style-type: none"> • The School of Physiotherapist a 13-member country school <ul style="list-style-type: none"> - didactic teaching - practical • This is a 3-year diploma program. 	<ul style="list-style-type: none"> • Provides an average of 7 Jamaican graduates annually. • Experiences difficulty in recruiting trainees 	<ul style="list-style-type: none"> • High cost of fees and books. • Salaries are low • Inadequate opportunities for career growth.
Nurses	<ul style="list-style-type: none"> • There are 7 schools of nursing comprising 6 government operated and one private/church operated <ul style="list-style-type: none"> - Kingston School of Nursing - U.W.I Hospital - West Indies College - Bellvue School of Nursing - EXED Community College - Cornwall School of Midwifery - West Indies School of Public Health • Duration of training is 3-6 years depending on specialization <ul style="list-style-type: none"> - didactic - practical work 	<ul style="list-style-type: none"> • Capacity exists • Average annual output over period 1983-1986 was 287. • Average after 1986 will fall to just over 200 due to reduced intake since 1984. • Present demand for graduates is 260 per year. • Due to attrition of 300 per year, training output will have to be 450/year for the next 5 years 	<ul style="list-style-type: none"> • Under estimated projected needs. • Reduced financial allocations.

TECHNICAL ANALYSIS - PUBLIC SECTOR

TABLE I - 14 (CONT'D) JAMAICAN PUBLIC SECTOR HEALTH CARE: TRAINING REQUIREMENTS
FOR KEY SKILLS AND SUPPLY SITUATION

121

PROFESSION OR MAIN TRAINING AREAS	INSTITUTION (S) PROVIDING SKILLS AND MODE OF TRAINING	OUTPUT CAPACITY AND SUPPLY SITUATION	KEY REASONS FOR CONSTRAINTS
Medical Doctor - Undergraduate	University of the West Indies a 14-member country school - Didactic teaching - Seminars and tutorials - clinical practice complete program is 6 years.	<ul style="list-style-type: none"> Can supply only 110 graduates per year with Jamaicans accounting for 50 - 65% Present demand for new graduates allowing for attrition is 108 per year 	<ul style="list-style-type: none"> Inadequate training facilities Hospital training school underfinanced Inadequate staffing
Dentists	No dental schools - Jamaicans are trained overseas		
Dental Nurses and Assistants	Dental Auxiliary School a 13-member country school - didactic teaching - field training - practical work under close supervision Duration of Training - 2 years for Dental Nurse - 6 months for clerical assistance.	<ul style="list-style-type: none"> The school supplies 18 dental nurses for 13 territories annually An average of 1 Jamaican graduate per year Present need for new dental nurses/assistant is 5 per year 	<p>The school is underfinanced</p> <p>A limited number of Jamaicans are in the program.</p>

TABLE I - 14 (CONT'D)

JAMAICA PUBLIC SECTOR HEALTH CARE: TRAINING REQUIREMENTS
FOR KEY SKILLS AND SUPPLY SITUATION

<u>PROFESSION OR MAIN TRAINING AREAS</u>	<u>INSTITUTION (S) PROVIDING SKILLS AND MODE OF TRAINING</u>	<u>OUTPUT CAPACITY AND SUPPLY SITUATION</u>	<u>KEY REASONS FOR CONSTRAINTS</u>
Medical Technologist	College of Arts Science and Technology. 4 years training comprising - 3 years of academic - 1 year of internship.	Annual • Average output is 16 • Annual demand for graduates is 35 • Severe inability to retain graduates.	High attrition to private sector.
Nutritionists	University of the West Indies. 2 years program comprising - 1 year academic - 1 year project assignment.	• Average output is 4 graduates per year. - -	No major constraints
Health Management	University of the West Indies 1 year diploma course - academic - case studies Program started only 1984.	• Capacity excellent • Annual average output is about 4 • Continuity doubtful Demand is for about 8 per year.	• Inadequate grant • Inadequate government support.

2021

ECONOMICAL ANALYSIS - PUBLIC SECTOR

TABLE I - 14 (CONT'D) JAMAICAN PUBLIC SECTOR HEALTH CARE: TRAINING REQUIREMENTS FOR KEY SKILLS AND SUPPLY SITUATION

PROFESSION OR MAIN TRAINING AREAS	INSTITUTION (S) PROVIDING SKILLS AND MODE OF TRAINING	OUTPUT CAPACITY AND SUPPLY SITUATION	KEY REASONS FOR CONSTRAINTS
Public Health	West Indies School of Public Health 3 year course - academic - practice	Average • Annual output is 15 • Average annual demand is for graduates.	• Inadequate training staff • Slow growth in demand.
Ambulance Response Team	None	Annual demand is for about 65 graduates.	• No funding • No organization • No priority.
Dietiticians	None	• Scholarships for overseas training discontinued • Annual demand for graduates is low. (about 2 per year)	• Salaries too low to encourage graduates to return.

The turn around time in the private sector for the service with drugs, is 89 minutes, with 45 minutes (51%) spent on receiving services. Table 16 illustrates the turn-around time without drug services at a public sector clinic; while Exhibit 1-8 presents a comparative analysis patient turn-around with drug services being involved.

An improved service delivery system is also required to improve the productivity of professional and auxiliary personnel. The development of such a system at this time would be quite timely given: the high degree of under utilization and improper use of skills of nurses, dentists, doctors and other key personnel who are in short supply because of the high rates of attrition among them. This system will also have to introduce incentive schemes for staff members to improve their comparative levels of compensation and to encourage them to perform more effectively.

E. Administration

Financial administration and management systems are very weak in the health care delivery centers. Even though there is a cost-recovery policy, only about 18% of the estimated J\$29 million collectable revenues are collected. The financial administrative instruments as illustrated in Exhibits 6 and 7 are not effective. An improvement in the collection system has the potential to increase collections from J\$5 million to as much as J\$29 million. Such a system will have to be three pronged.

- One subsystem should be developed to be used for determining the medically indigent;
- A second subsystem will have to be designed to manage collections;
- A third subsystem should be designed to determine the cost of services on an on-going basis, so that the fee structure could be more realistic.

Human resources related matters feature prominently as the main driving forces behind the current situation in the public sector health services. If initiatives are immediately taken to solve the human resources related problems particularly low salaries, poor working conditions and shortfalls in training and skills upgrading, the sector could be on its way to recovery.

III. KEY ISSUES AND OUTLOOK

The public sector health care services face a formidable set of issues. They revolve around human resource development, quality of services, efficiency/productivity and financial administration. Those issues are summarized and analysed schematically in Exhibit 9 which follows.

Patients' turn-around time is more excessive at public sector facilities mainly due to severe staff shortage and weak administrative systems. This excessive turn-around time is a major attribute to the poor quality of services that patients receive. A patient who has to wait 248 minutes (4.1 hours) for health care services, and is sometimes required to travel over 2 hours to and from the service facility, cannot perceive the service to be good. Furthermore, patients frequently wait for the 248 minutes and are still required to return because they did not see the doctor or obtain the drugs from the pharmacist.

TABLE I - 16

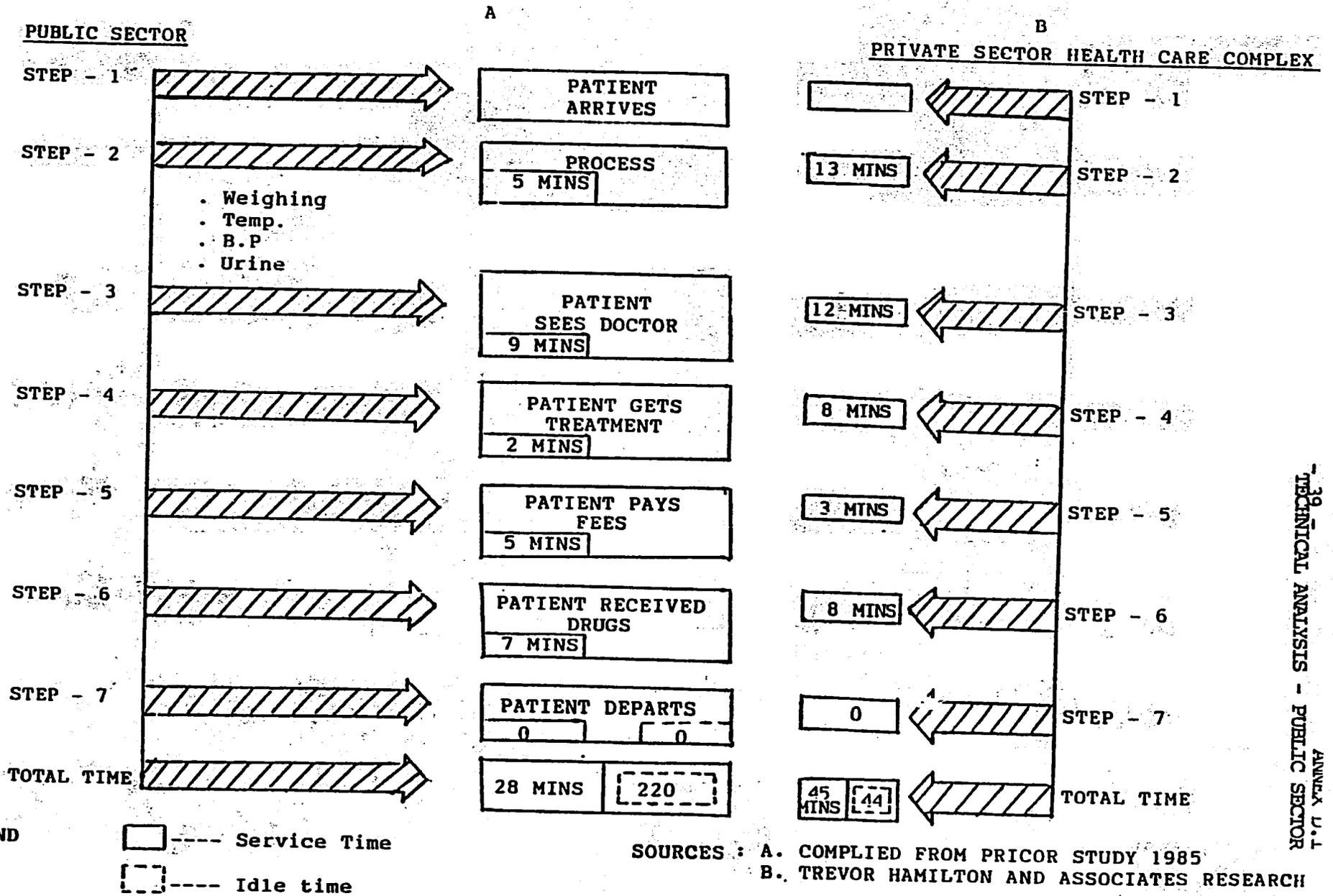
JAMAICAN PUBLIC SECTOR HEALTH CARE. PATIENT WAITING TIME
AT HEALTH CENTERS IN MINUTES [WITHOUT DRUGS]

121

SERVICE	TYPE - I			TYPE - II			TYPE - III			AVERAGE FOR ALL 3 TYPES		
	SERVICE TIME	IDLE TIME	TOTAL TIME	SERVICE TIME	IDLE TIME	TOTAL TIME	SERVICE TIME	IDLE TIME	TOTAL TIME	SERVICE TIME	IDLE TIME	TOTAL TIME
Antinatal	19	70	89	22	112	134	26	135	161	38	90	128
Postnatal	11	59	70	28	24	152	30	125	155	59	69	126
Child Welfare	12	80	92	17	120	137	16	138	154	15	113	128
Family Planning	10	32	42	11	59	70	15	58	73	9	53	62
Dental	--	--	--	8	79	87	13	90	103	11	84	95
Curative	6	46	52	19	107	126	25	135	160	17	96	113
AVERAGE										25	84	109

Source: Computed from PRICOR Study.

JAMAICAN PUBLIC SECTOR HEALTH CARE: COMPARATIVE ANALYSIS OF PATIENT PROCESSING TIME WITH DRUGS



HUMAN RESOURCE ISSUES

JAMAICAN PUBLIC SECTOR HEALTH SERVICES:
CRITICAL ISSUES AND REQUIRED ACTIONS

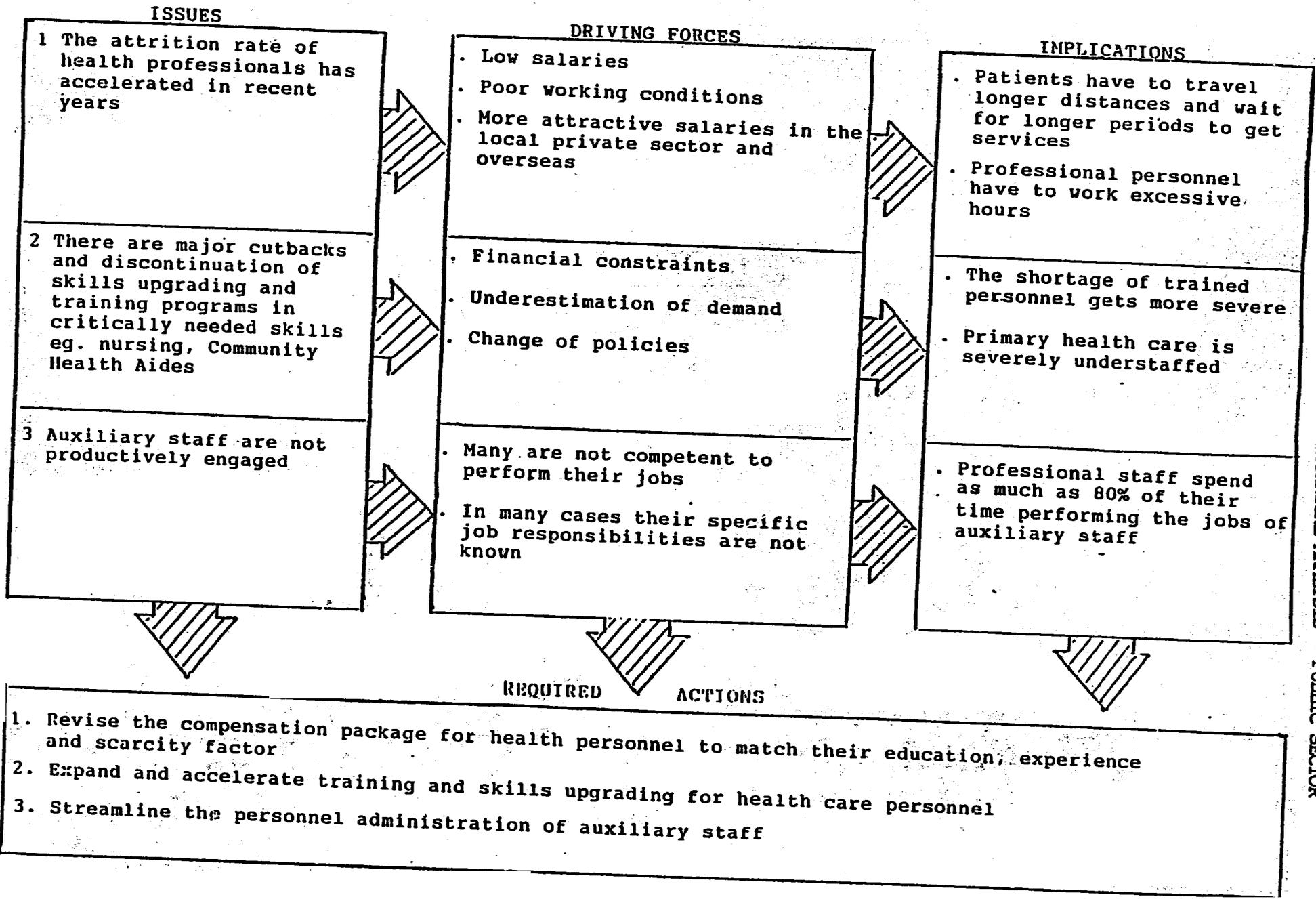
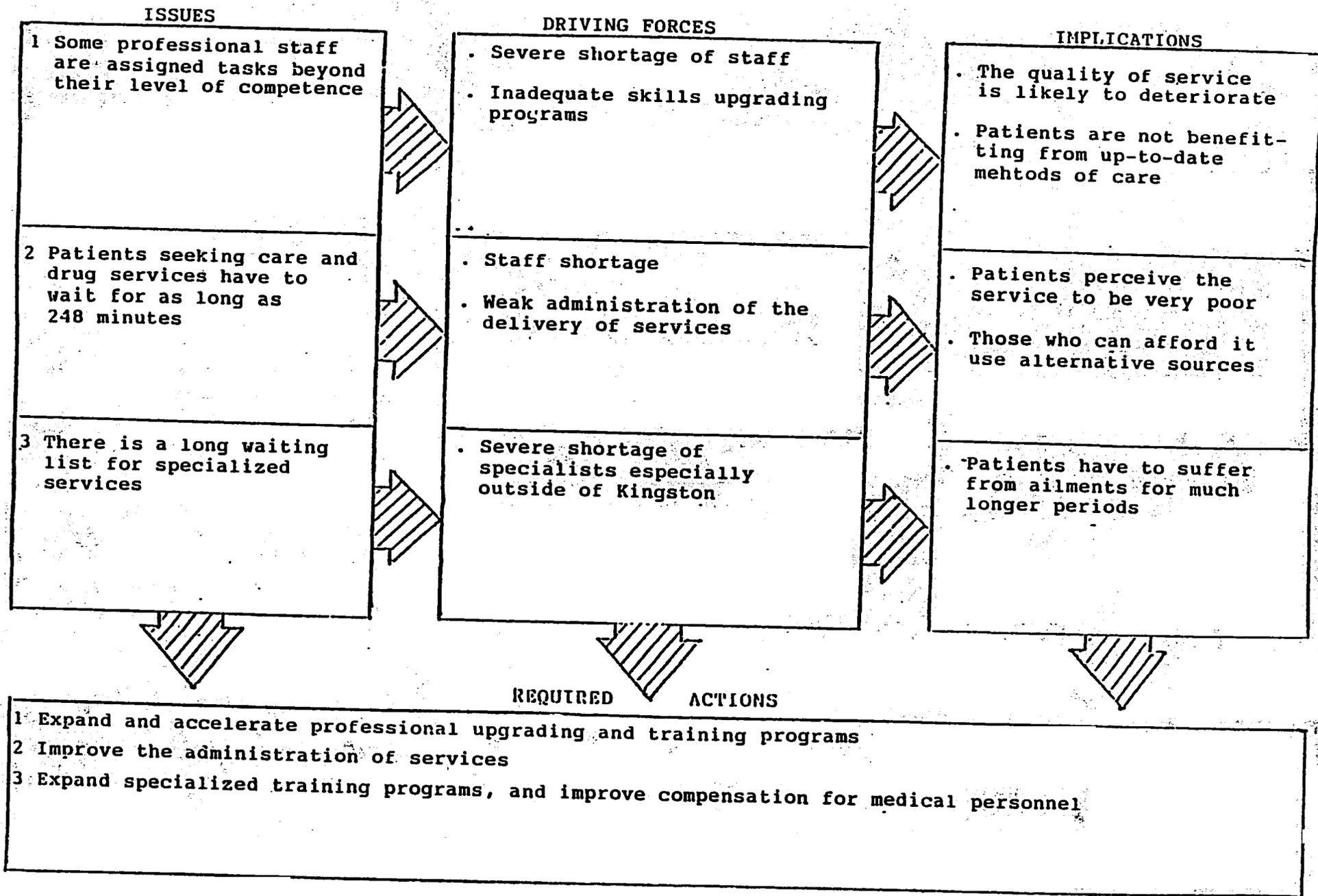


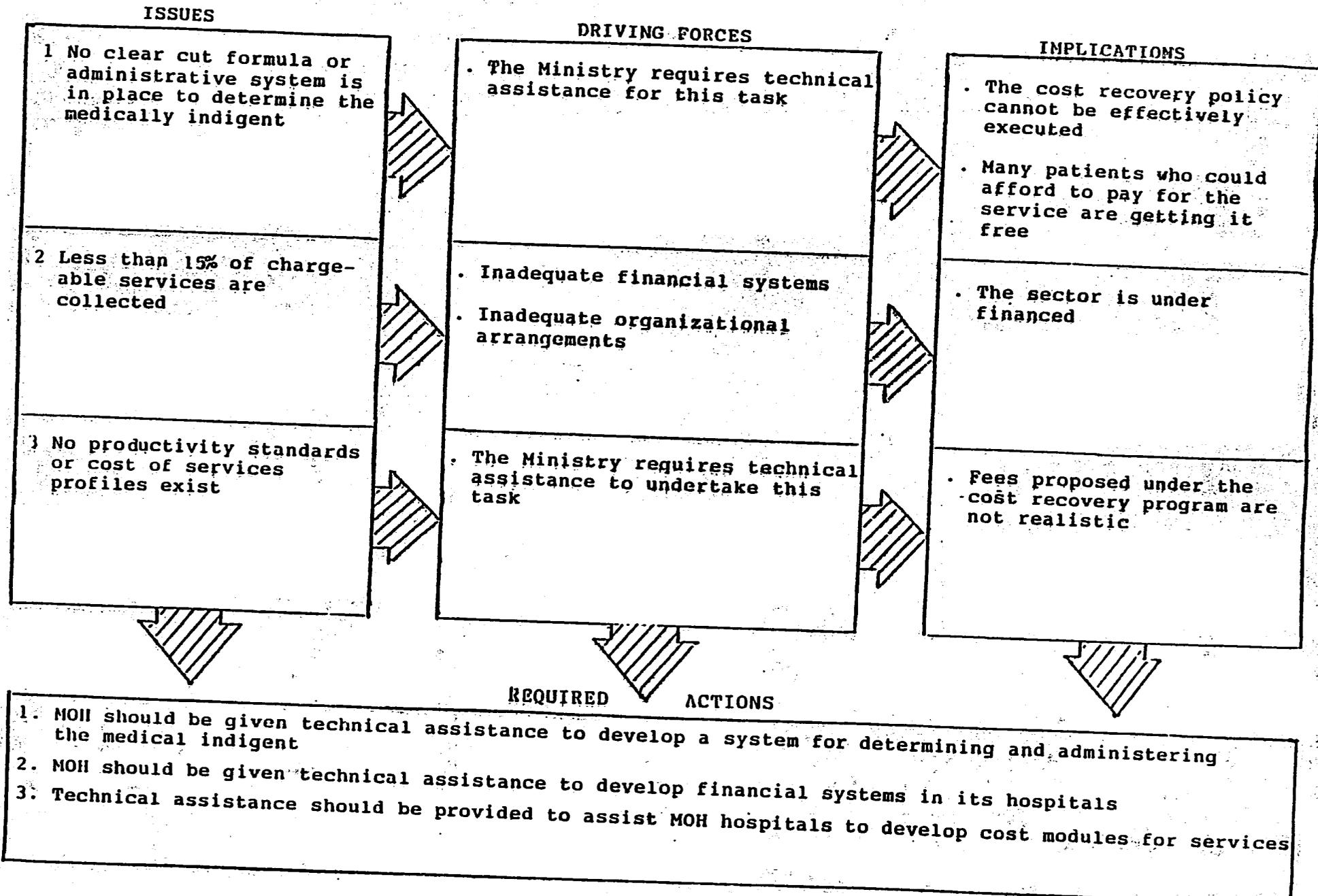
EXHIBIT I - 9 (CONT'D)
 QUALITY OF SERVICES ISSUES

JAMAICAN PUBLIC SECTOR HEALTH SERVICES:
 CRITICAL ISSUES AND REQUIRED ACTIONS

1271



TECHNICAL ANALYSIS - PUBLIC SECTOR



-43-

The Government intends to promote the expansion of the role of the private sector in health services as a strategy to improve the quality of services and financial administration. It is also promoting collaboration with the private sector as a vehicle to promote health insurance, so that as many individuals as possible will be able to pay for their health care.

The success of the contemplated program will require the creation of a suitable investment climate to encourage the private sector to expand its participation in health services. Health services were never regarded as an industry for private investment in Jamaica. Consequently, it is not eligible for participating in any of the investment encouragement schemes now promoting investment in tourism, export manufacturing and export agriculture.

The follow-up activities required to set the stage for promoting the private sector's role are therefore:

- . The development of a suitable policy framework to encourage the private sector;
- . The provision of technical assistance to enhance private sector initiatives.

If the appropriate environment and support provided the outlook for greater collaboration with the private sector is very sound.

IV. CONCLUSIONS

Based on the analysis, the following conclusions can be made.

1. The Jamaican Public Sector Plays a very Significant Role in Health Care Services
 - . It accounts for 93% of the hospital beds in the island.
 - . All of the local medical training institutions are public sector financed.
 - . It accounts for J\$337 millions or 68% of expenditure on health care in 1986.
2. The hospitals are not Organized to give Prominence to Cost-Effective Services and Enhancement of Quality Services
 - . Financial administration is fragmented and poorly positioned.
 - . Service improvement oriented functions such as maintenance, staff administration, stores and catering are fragmented in very low positions in the organization.
3. The Public Sector has the Capacity to Perform more Complexed Services than the Private Sector
 - . It has a wider range of specialists.
 - . It has a wider range of physical facilities.
4. Emoluments for Staffing Accounts for About 70% of the Recurrent Expenditure of the Public Sector Health Care Services
 - . Staff production is therefore critical in cost containment efforts.
 - . Streamlining of auxiliary staff whose functions are not always clearly defined is imperative.

130x

5. Less than 15% of the Potentially Recoverable Cost of Public Sector Health Care have been collected due to:
 - . Poor financial administration.
 - . The lack of an administrative mechanism for determining fee paying patients at hospitals.
6. The Standards of various Aspects of the Services are very Poor Mainly due to:
 - . Accessibility to doctors, dentists and specialized health care professionals is difficult.
 - . The turn-around time for patients is very long.
 - . The stays in hospitals are excessive.
7. Health Care Personnel are Paid Only A Small Fraction of the Pay of Other Professionals with Comparable Training and Experience. For Example:
 - . Doctors earn 52% of the pay of a Systems Analyst, a Financial Controller or a Specialist Engineer.
 - . A Registered Nurse earns 36% of the salary earned by an Accountant or an Insurance Sales person.
8. There is Urgent Need to Increase the Number of Personnel to Arrest the Severe Shortages
 - . Many training programs have been severely reduced over the past 5 years.
 - . The attrition rate among health services personnel is very high.
9. There is a Need to Expand the Continuing Education Programs for Health Personnel
 - . Many staff members are assigned duties outside of their areas of competence.
10. Professional Personnel are Unproductively Engaged by as Much as 80%
 - . They spend much of their time performing routine tasks.
 - . They perform some of the duties of the auxiliary staff who need to be reorganized in their jobs.

ANNEX D.2. TECHNICAL ANALYSIS - HEALTH INSURANCE INDUSTRY

I. OVERVIEW OF THE INDUSTRY

This section reviews the industry in seven areas: the size of the health insurance industry and key players; typical organizational structure in each company; the packages and adequacy of benefits; market characteristics; financial characteristics of the companies; national regulations and national insurance. Each topic is discussed in individual subsections as follows:

A. Size of the Industry

This subsection focuses on the number of policy holders and insured, the value of premiums, the key carriers, and the share of industry by economic activity.

There are about 333,000 insured comprising about 111,000 subscribers with insurance companies being carriers for 99% of the policies. Table 1 provides the details.

**TABLE 1
 JAMAICAN HEALTH INSURANCE INDUSTRY: INSURED BY
 INSURANCE COMPANIES AND OTHER CARRIERS IN 000**

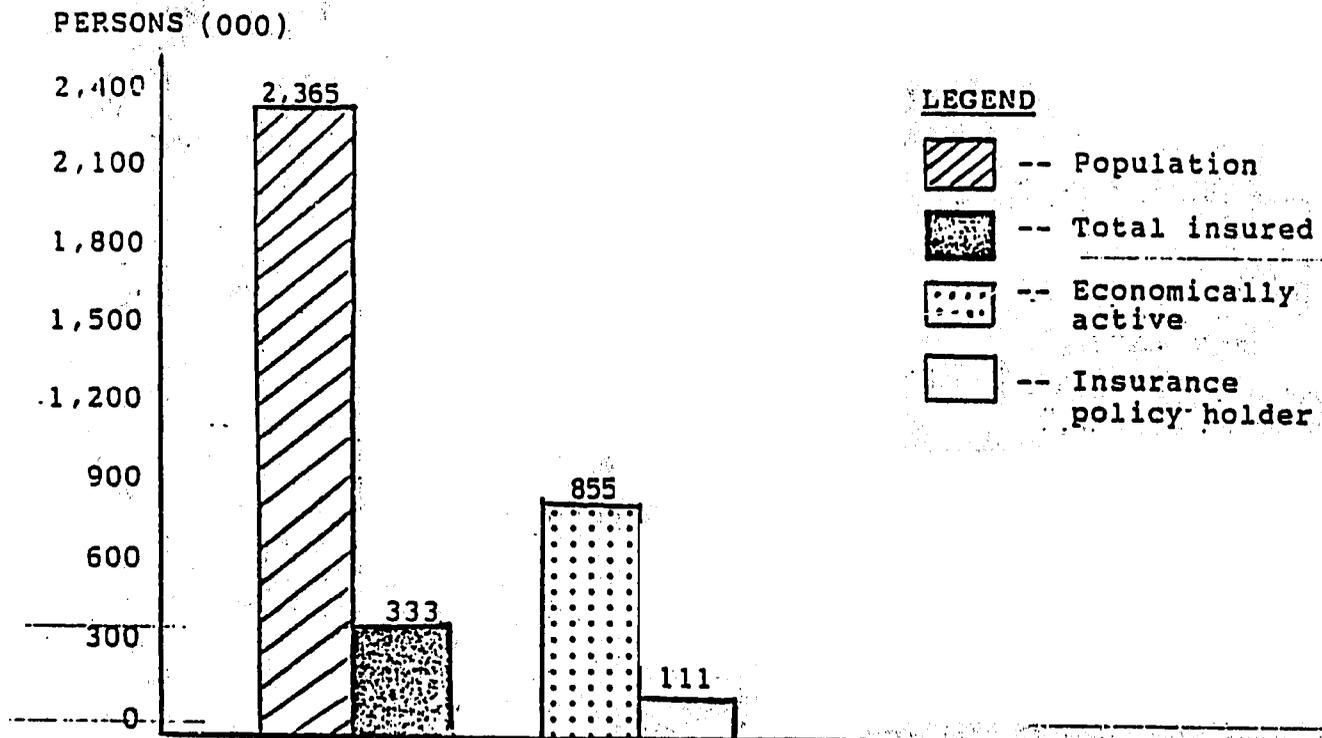
ITEM	NUMBER OF '000 INSURED	PERCENTAGE SHARE OF MARKET
INSURANCE COMPANIES		
Blue Cross	178	52.0
First Life	24	7.0
American Life	52	15.2
Mutual Life	16	4.7
Life of Jamaica	60	20.2
LARGE ENTERPRISES		
With self insurance for some categories of employers	3	0.9
TOTAL	333	100.0

Source: Insurance companies

The level of insured represents about 14% of the population, while the level of policy holders represent about 13% of the economically active as set out in Exhibit 1 below.

* This technical analysis is drawn from: "Review of the Jamaican Public Sector Health Services and the Health Insurance Industry." Trevor Hamilton and Associates. March 1989.

EXHIBIT II - 1. LEVELS OF HEALTH INSURANCE IN JAMAICA



Only a relatively small percentage of the economically active carry insurance policies due to the following reasons:

- Health insurance companies promote their policies, in the main to the highly formalized wage employed sectors such as the civil service, large, medium and some small scale manufacturing companies and large commercial and financial organizations where the schemes can be administered most cost effectively.
- Companies and organizations over the years have provided life insurance schemes in negotiated personnel contracts with unions, and for non-urban workers. Health coverage has gained in popularity and companies find it convenient to link life insurance schemes and find it efficient if these be provided by the same company. Table 2 illustrates.

TABLE 2
JAMAICAN HEALTH INSURANCE INDUSTRY: DISTRIBUTION OF
POLICY HOLDERS BY ECONOMIC ACTIVITY ON TYPE OF
INDUSTRY 1987

COMPANY	CIVIL SERVICE	GOVERNMENT	MANUFACTURING	COMMERCIAL AND RELATED SERVICES	AGRICULTURE	SELF- EMPLOYED
Blue Cross	50	Negligible	25	25	0	0
First Life		-	1	99	0	0
The Jamaica Mutual Life Assurance Society		5	5	90	0	0
Life of Jamaica		10		90	0	0
American Life				100	0	0

Source: Insurance companies

Over 40% of the economically active are engaged in self employment. They are not targets for the health insurance industry because of the following:

- The self-employed live and operate in remote areas where the cost of servicing claims from the urban centres where the insurance companies concentrate would be prohibitive;
- They do not have formal payroll or other transaction systems to facilitate automatic deductions;
- The bureaucratic framework required by insurance companies to administer these policies is prohibitive in cost.

TABLE 3
JAMAICAN EMPLOYED LABOUR FORCE
BY OCCUPATIONAL GROUP OCTOBER 1987

TYPE	EMPLOYMENT '000	% OF TOTAL EMPLOYED
White Collar	157	18.4
- Professional admin. and manager	62.3	7.3
- Clerical and Sales	94.7	11.1
Blue Collar	226.1	26.6
- Craftsmen, Processing and operatives	132	15.4
- Unskilled, manual and general	94.1	11.0
Service	117.7	13.3
Self-employed	352.9	42.3
Not Specified	1.3	0.2
TOTAL	855	100.0

Source: Economic and Social Survey 1987 Table 16.5

The public sector which provides about 90% of the health care services does it virtually on a "free for all" basis

- the scale of fees is too low to require a third party - the employer or insurance carrier - to pay
- only 12% of recipients pay for some of the services they receive

The quality of paid services versus unpaid ones, hardly differ significantly to stimulate the demand for health insurance. The driving forces behind the generally poor services are:

- severe shortages of key health personnel in both the public and private sector facilities
- health care facilities and professional personnel are unevenly distributed outside of Kingston. Consequently accessibility to health care is very difficult for more than 50% of the population.

The estimated value of annual premium collected by the insurance industry is J\$79 million between insurance carriers and a few self insured employers. Five insurance companies dominate the industry, with Blue Cross of Jamaica, the leader accounting for 54% of the value of the industry. Table 4 which follows, provides the details.

TABLE 4
JAMAICAN HEALTH INSURANCE INDUSTRY: VALUE OF ANNUAL PREMIUM FOR HEALTH RELATED INSURANCE

<u>INSURANCE COMPANIES</u>	<u>1987 ESTIMATED J\$M</u>
Blue Cross of Jamaica	42.5
First Life	7.5
The Jamaica Mutual Life	6.6
Life of Jamaica	6.2
American Life	11.1
Self Insured Employers	5.0
TOTAL J\$MILLION	78.9

Source: Insurance Companies

Blue Cross has dominated the industry primarily because health insurance is its only business. All other carriers are primarily engaged in life insurance. Table 5 which follows, provides details of each carrier in terms of its main type of business and nationality of ownership.

TABLE 5
JAMAICA: KEY PLAYERS IN THE HEALTH INSURANCE INDUSTRY

<u>COMPANY</u>	<u>MAIN TYPE OF BUSINESS</u>	<u>NATIONALITY OF MAIN OWNERSHIP</u>
Blue Cross of Jamaica	Health Insurance	U.S. - Jamaica
First Life	Life Insurance	Jamaica
The Jamaica Mutual Life	Life Insurance	Jamaica
Life of Jamaica	Life Insurance	Jamaica
American Life Insurance Co.	Life Insurance	U.S.

Source: Insurance Companies

B. Typical Organizational Structure of Health Carriers

All of the health carriers are adequately organized to promote health insurance services, their client's needs and undertake risk analysis. They have the key organizational characteristics to enable them to promote and manage health insurance schemes effectively. Those characteristics are:

136K

- . A marketing division
- . Actuarial services
- . A data processing or management information systems division
- . A claims division

Blue Cross, which provides health insurance services only has a more detailed organizational approach to health insurance. For example its organization comes with:

- . A committee with medical and hospital relations
- . A provider relation unit

Since they operate a medical centre, they also have a managing committee responsible mainly for the medical centre.

Exhibits 2 to 4, which follow, illustrate the organizational structure of the leading health insurance organizations.

C. The Health Insurance Coverage and Adequacy of Benefits

The basic plans offered by the health insurance industry cover most services, with options to include optical, dental and maternity. The range of services covered as basics include: hospital room and board, miscellaneous hospital expenses, surgeon fees, anaesthetic fees, home visits, office visits, consultation fees, drugs, ambulance services, and laboratory tests.

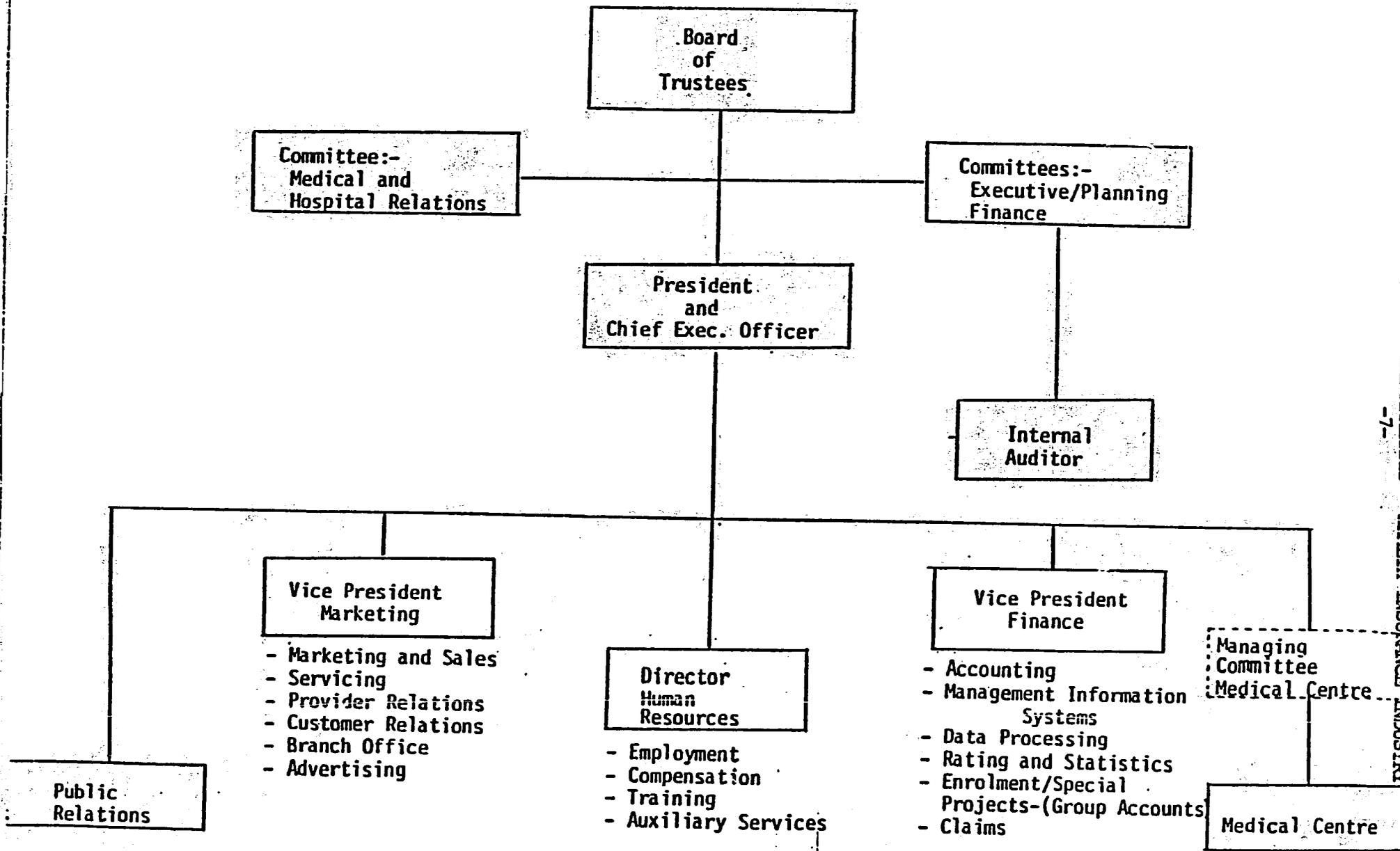
The cash allowance per case averages over 3 times the fees charged at public facilities. On average, allowances are about 30% lower than the fees charged by private providers. Table 6 provides the details on the features of the basic plan and comparative fees for services under the plan.

Even though public sector provided services are cheaper than those provided by the private sector counterparts, comprising mainly hospitals and a range of medical specialists, the latter continue to enjoy excessive and growing demand for their services because of the following:

- . There is a severe shortage of health care personnel in the public sector.
- . Waiting time for service at public sector facilities is much longer than that at the private ones.

BLUE CROSS OF JAMAICA - ORGANISATION

1831

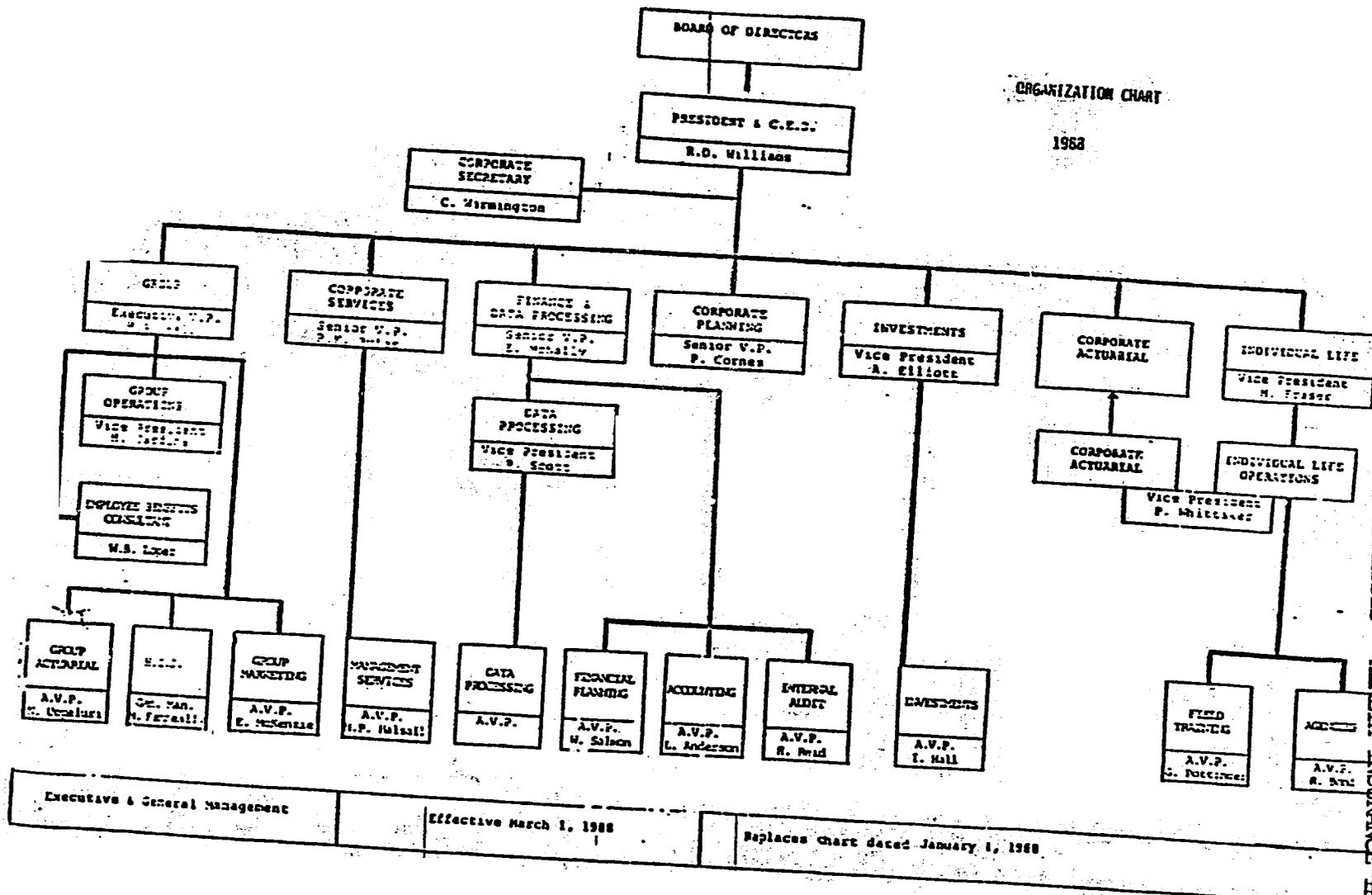


TECHNICAL ANALYSIS - HEALTH INSURANCE INDUSTRY -7- ANNEX D.2

JAMAICA: ORGANIZATIONAL STRUCTURE OF LIFE OF JAMAICA

ORGANIZATION CHART

1968



Executive & General Management

Effective March 1, 1968

Replaces chart dated January 1, 1968

TABLE 6
 JAMAICA HEALTH INSURANCE INDUSTRY: FEATURES OF
 BASIC PLAN AND RELATED HEALTH SERVICES FEES

MAIN BENEFITS	AVERAGE VALUE OF COVERAGE PER CASE	AVERAGE FEES FOR SERVICE IN PUBLIC SECTOR	AVERAGE FEE FOR SERVICE IN PRIVATE SECTOR
- Hospital room and board	110/day	47	169
- Miscellaneous expenses in hosp.	1,200	varied	varied
- Surgeon fees	1,000	N/A	1,200
- Assistant surgeon fee	400	65	520
- Anaesthetist fee	400	65	700
- Home visit	30	N/A	45
- Office visit	26	N/A	22
- Hospital visit	26	10	22
- Consultation fee	100	N/A	115
- Ambulance service	fully paid	8/mile	11/mile
- Laboratory test for outpatients	200	20 (series)	80

D. Market Characteristics

As indicated previously, over 80% of the potential insurance market has not been realized due to the administrative constraints, and unfavorable delivery logistics. The other market characteristics which should be analysed in this section are the premiums and the competitiveness of the market.

The average premium for basic policies is J\$448 for individuals and J\$1,259 for family and has been growing at 21% to 23% annually (21.3% for family and 23.2% for individual policies). The steep increases in the price of drugs have been the main driving forces behind increases in premiums. The price of drugs increases by an average of 17.5% per year 1983-1988 while the national inflation rate was 14.4%. Table 7 provides the details on premiums and the rates of inflation.

140x

TABLE 7
JAMAICA HEALTH INDUSTRY: AVERAGE ANNUAL
INSURANCE PREMIUM FOR BASIC GROUP PLANS 1985-1988

YEAR	INDIVIDUAL	FAMILY
1985	244.00	713.51
1986	265.08	777.48
1987	315.30	925.02
1988	448.47	1,259.90
<hr/>		
Average annual inflation rate for premium (%)	23.2	21.3
<hr/>		
Average annual national inflation rate 1985-1988	14.1	
<hr/>		
Average annual inflation rate for drugs 1985-1988	17.5%	

Sources: (a) Insurance companies for Premiums and Inflation Rates for Drugs; (b) Economic and Social Survey of Jamaica for National Inflation rate.

The market has been very competitive in terms of levels of premiums as shown in Exhibit 5. The key driving forces behind the high level of competitiveness in premiums are:

- All the health insurance carriers are targeting the same market segments.
- The market is low income while the cost of services especially drugs has been increasing.
- Employers procure policies on competitive basis.

E. Financial Characteristics

Health insurance accounts for only 18% of the total sales of insurance companies participating as health insurance carriers:

- It accounts for 100% of Blue Cross sales.
- It accounts for a combined share of 7.4% of the sales of the insurance companies participating as health insurance carriers. Table 8 provides the details.

Health insurance represents a very small share of sales of life insurance companies because it is generally a low profit or unprofitable business.

- In 1986, Blue Cross which represents over 50% of the industry recorded a loss of J\$3.0 million on a premium of J\$40 million.
- Life of Jamaica, which operates the HMO is now considering new strategies due to severe losses on same.

JAMAICA: ORGANIZATIONAL STRUCTURE FOR MUTUAL LIFE INSURANCE CO.

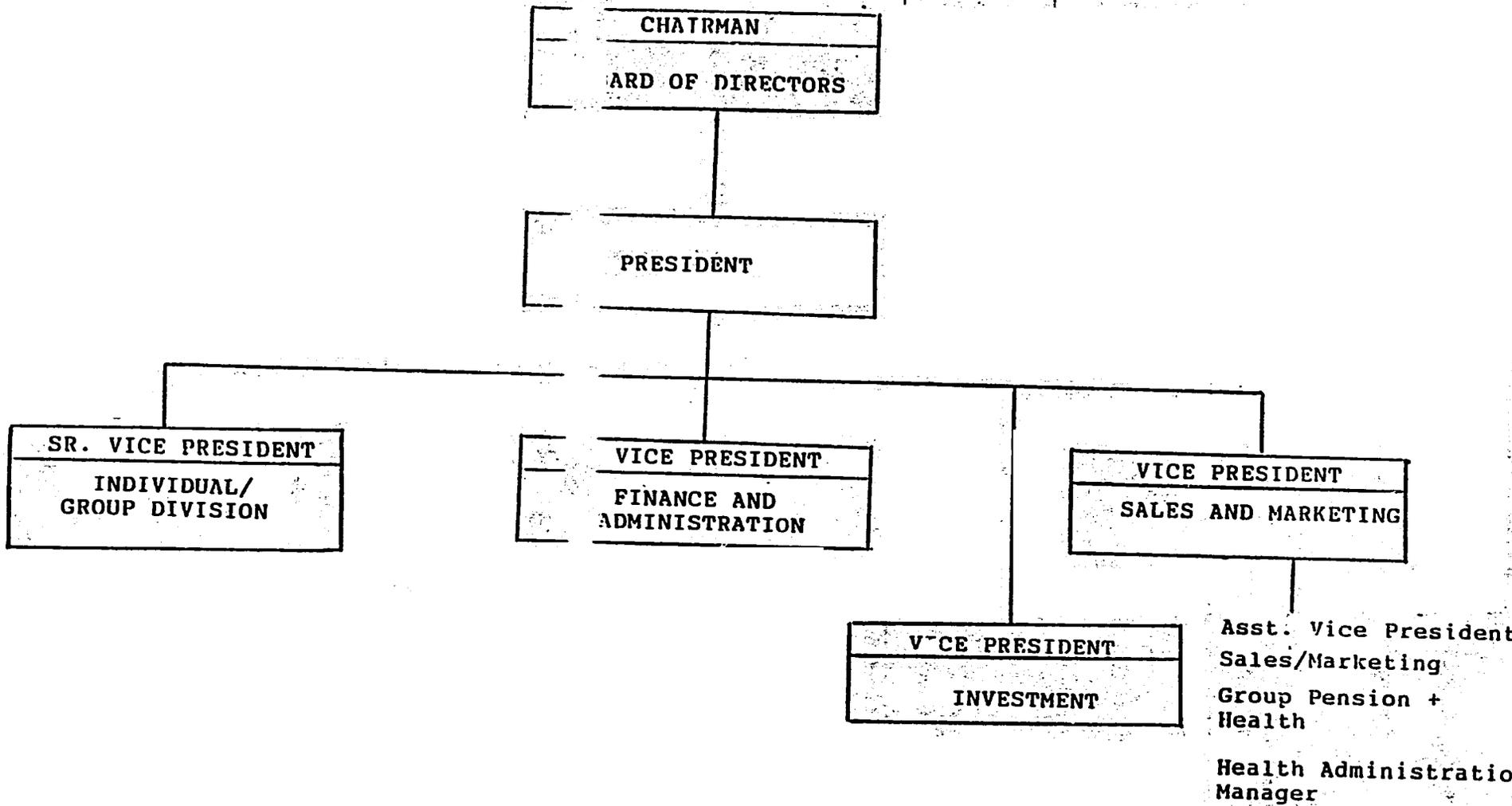


TABLE 8
JAMAICA HEALTH INSURANCE INDUSTRY: HEALTH INSURANCE
BUSINESS AS A PERCENTAGE OF INSURANCE PREMIUMS
COLLECTED BY THOSE IN HEALTH INSURANCE 1986 IN J\$MILLION

COMPANY	TOTAL INSURANCE PREMIUM J\$MILLION	HEALTH INSURANCE PREMIUM J\$M	HEALTH INSURANCE AS PERCENTAGE OF TOTAL INSURANCE BUSINESS
A	40.1	40.1	100.0
B	7.0	28.9	24.2
C	9.3	38.5	24.2
D	5.7	149.5	3.8
E	1.0	92.3	1.1
TOTAL	63.1	349.3	18.1%

Source: Superintendent of Insurance

The total net worth of the 5 companies which are health insurance carriers is J\$213 million with Mutual Life, which accounts for less than 8% of the health insurance industry, accounting for J\$122 million or 57% of the net worth of the industry; while Blue Cross, the leading health insurance company, accounting for only J\$6.2 million or only 2.9% of the net worth of the industry. Table 9 provides a break down of the net worth by company.

Blue Cross has the widest range of related experience to collaborate with the public sector health care services primarily because it accounts for over 50% of the industry and it has an international track record of professional related services in health care. The four life insurance companies especially Mutual Life and Life of Jamaica have stronger financial bases for supporting capital investment with a blend of relatively limited health insurance experience in the public sector health services.

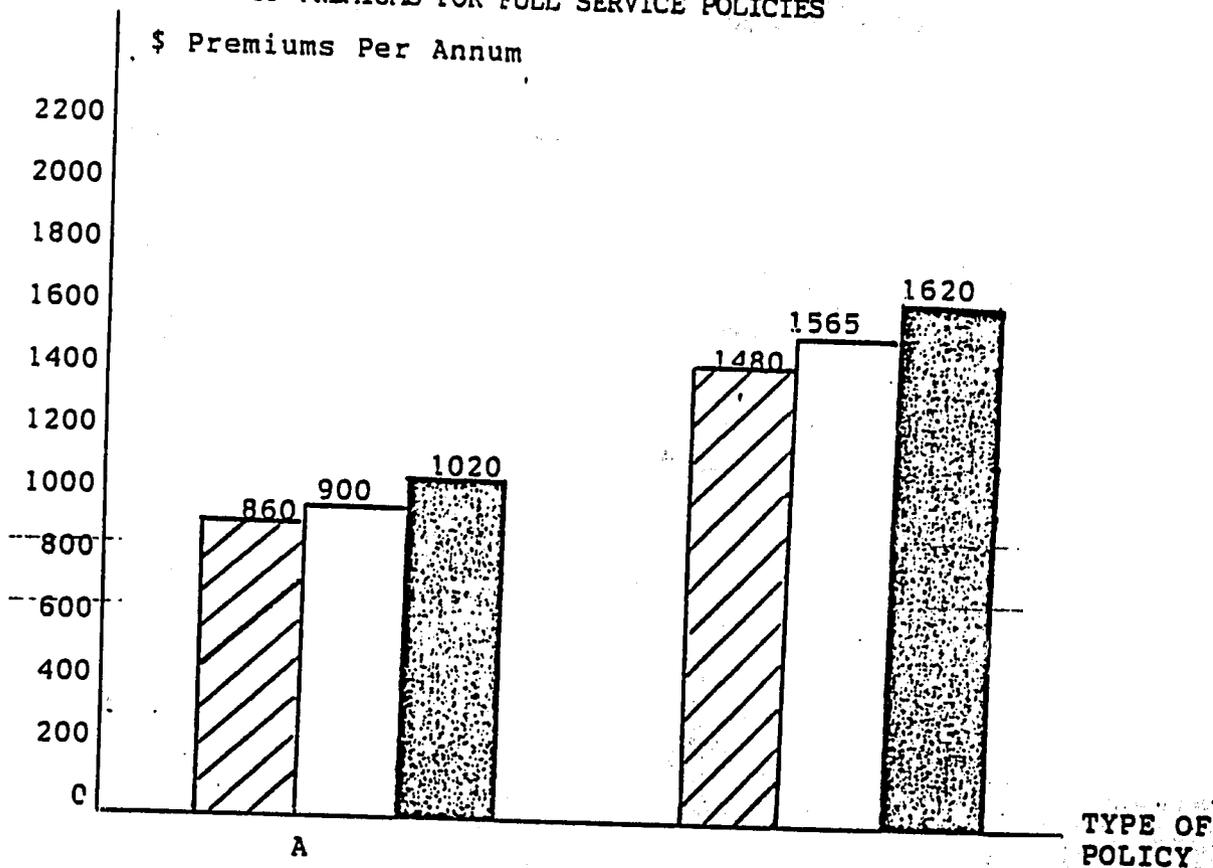
The four life insurance companies have showed a strong preference for low risk investments concentrated in:

- . Governments' bonds
- . Mortgage loans secured by real estate
- . Real Estate
- . Deposits

Table 10 which follows illustrate that bonds, real estate and real estate secured mortgage loans and deposit account for J\$1,336 million or 87% of their investments.

EXHIBIT 11-5

JAMAICAN HEALTH INSURANCE INDUSTRY: COMPETITIVENESS
 OF PREMIUMS FOR FULL SERVICE POLICIES



Source: Insurance Companies.

LEGEND

-  ----- Lowest Premium
-  ----- Average Premium
-  ----- Highest Premium
- A ----- Individual
- B ----- Group

144x

5/11

**JAMAICAN HEALTH INSURANCE INDUSTRY: NETWORTH
OF KEY PLAYERS 1986 IN \$ MILLIONS**

<u>COMPANIES</u>	<u>Components/Value of Networth</u>						
	<u>TOTAL NETWORTH</u>	<u>PAID-UP CAPITAL</u>	<u>HEAD OFFICE ACCOUNT</u>	<u>SHARE PERMIUM</u>	<u>CAPITAL RESERVE</u>	<u>GENERAL RESERVES</u>	<u>UNDISTRIBUTED PROFITS</u>
Blue Cross of Jamaica	6.2				4.7	0.2	1.3
First Life	9.9	15.9			1.8	7.0	(14.8)
The Jamaica Mutual Life Assurance Society	122.3	-			112.4	9.9	-
Life of Jamaica	66.2	5.7			6.3	44.5	9.7
American Life Insurance Co.	8.1	2.7			3.4	2.0	0
TOTAL \$ MILLION	212.7	24.3			128.6	63.6	(3.8)

SOURCE: Compiled from office annual report of the Superintendent of Insurance, Jamaica 1986

These insurance companies are reluctant to make any major investment in long term oriented and relatively more risky ventures such as health care facilities or development and improvement of health care services. They justify their attitudes on the following grounds.

- . Resources belong to policy holders.
- . They must maintain a very high percentage of their portfolio in "near cash".
- . The nature of the industry restricts it to low risk investments.
- . The general public's perception of health care is that it is a right bestowed by government.
- . In general, the public is not sophisticated in their perception or use of insurance.

F. National Regulation

The Superintendent of Insurance, Government organization, is responsible for monitoring the practice of all insurance companies to ensure that they operate to satisfy certain standards revolving around liquidity, ownership, procedure for claims, and reinsurance. Table 11 highlights the key features of the regulatory requirements of health insurance companies operating in Jamaica.

G. National Insurance

The National Insurance Scheme (NIS) was established over 20 years ago as a component of National labour standards for all employed persons. The scheme which is administered by government, requires all employers and employees, over age 18 by law, to subscribe to the scheme. The employer subscribes 2.6% of each employee's gross pay while each employee contributes 2.2%.

The scheme provides for medical benefits arising from job related injury and disability. Table 12 provides the summarized features of the legal requirements, the range of benefits, and the administrative framework applicable in the scheme.

TABLE 11
 JAMAICA HEALTH INSURANCE INDUSTRY: KEY REGULATORY FEATURES

<u>KEY REQUIREMENTS UNDER THE INSURANCE ACT</u>	<u>KEY FEATURES</u>
1. All insurance companies must be registered to provide health insurance	<ul style="list-style-type: none"> . Its corporate and legal status in Jamaica . Its range of business activities . Its operational procedures for claims
2. Majority ownership should be Jamaican	<ul style="list-style-type: none"> . Business details on its agents . Its asset: liability situation . At least 51% of the ownership should be Jamaican

146X

TABLE 11 (cont'd)

KEY REQUIREMENTS UNDER THE INSURANCE ACT	KEY FEATURES
3. If it is a new company it must satisfy certain financial and organizational requirements	<ul style="list-style-type: none"> . Minimum paid up capital of J\$10 million . Proof of its viability . Proof of adequate organizational arrangement & staffing
4. The company must make annual returns to the Superintendent of Insurance	<ul style="list-style-type: none"> . Its balance sheet . Profit and loss situation . Its key professional service agents - auditors - actuaries . Its level of reserves . Its re-insurance arrangements

TABLE 12
JAMAICAN NATIONAL INSURANCE SCHEME: MAIN FEATURES

LEGAL	ADMINISTRATIVE	
	MAJOR BENEFITS	FRAMEWORK
<ul style="list-style-type: none"> . Mandatory for all employed persons to participate . All persons aged 18-64 <ul style="list-style-type: none"> - Wage employed - Self employed - Other insured employed persons . Subscription is joint <ul style="list-style-type: none"> - Employer - Employee . Required contribution is approximately 4.8% of gross pay <ul style="list-style-type: none"> - Employer pays 2.6% - Employee pays 2.2% 	<ul style="list-style-type: none"> . Benefits <ul style="list-style-type: none"> - Employee injury - Employment injury death benefit - Prescribed medical treatment - Employment disability . Level of benefits <ul style="list-style-type: none"> - J\$9 maximum for doctor's visit - Treatments J\$5-12 maximum - Operations J\$15.75 - J\$31.50 - Lab. tests J\$9-12 - Physiotherapy J\$31.50 max. 	<ul style="list-style-type: none"> . Automatic payroll check-off for submission . Legal action can be taken for non-compliance . Prescribed list of health care providers.

II. KEY ISSUES IMPACTING ON THE INDUSTRY

There are at least eight key issues impacting on the Jamaican health insurance industry in the following ways:

- . The cost of health insurance to subscribers
- . The viability of the plans
- . The profitability of the carriers
- . The growth of the industry
- . The level of financial support available to reduce government's required support

Table 13 which follows, summarizes the main concerns, the strategies (if any) under consideration in the insurance industry to address them, and the required level of government and other support.

III. OUTLOOK

A. Projected Role of Insurance Industry

The two leading companies, Blue Cross of Jamaica Ltd. and Life of Jamaica have positive intentions to assist in improving the management of health services as follows:

Blue Cross proposes to provide the following services:

- Introduction and administration of cost containment systems at hospitals.
- Administration of a scheme for the medically indigent.

Life of Jamaica could see its role expanded as follows:

- Design and management of the health care delivery system.
- Monitoring of cost containment.

148x

149

**JAMAICAN HEALTH INSURANCE COMPANIES: BREAKDOWN OF INVESTMENTS
IN J\$MILLION 1986**

COMPANY	TOTAL \$M	FIXED INTEREST IRREDEEMABLE \$M	FIXED INTEREST RE- DEEMABLE BEYOND 1 YEAR (MOSTLY GOVERNMENT) \$M	VARIABLE INTEREST RE- DEEMABLE BEYOND 1 YEAR \$M	LAND \$M	SPECIALIZED MORTGAGE AND LOANS REDEEMABLE BEYOND 1 YEAR \$M	INVESTMENT MORTGAGE AND LOANS REDEEMABLE IN 1 YEAR \$M	DEPOSITS \$M	OTHER \$M
BLUE CROSS OF JAMAICA	2.0	0	1.3				0.7	0	0
FIRST LIFE	76.9	0	17.8	24.6	3.8	30.0		0.7	0
THE JAMAICA MUTUAL ASSURANCE SOCIETY	1039.4	0.3	161.3	312.2	14.9	196.7	0.4	154.6	0
LIFE OF JAMAICA	353.1	0	45.5	67.3	133.8	100.3	0.6	5.9	0
AMERICAN LIFE INSURANCE COMPANY	65.3	0	29.3	0	0	22.5	0	13.5	0
TOTAL	1537.0	0.3	255.2	404.1	152.5	349.5	1.7	174.7	199.0

Source: Individual Companies and Office of the Superintendent of Insurance

1021

JAMAICAN HEALTH INSURANCE INDUSTRY:
MAJOR CONCERNS AND STRATEGIES IN PIPELINE AND REQUIRED SUPPORT

MAJOR CONCERNS	STRATEGIES UNDER CONSIDERATION	REQUIRED SUPPORT
1. Excessive prices for drugs are driving up the cost of health insurance	Set maximum allowance for drugs according to illness	<ul style="list-style-type: none"> • Government should introduce generic drugs into the system Medical personnel should help to promote the use of generic drugs
2. An abuse of Medical procedure and office visits are eroding the viability of health insurance plans	<p>Companies will be establishing mechanisms for early detection of abuse.</p> <p>Companies will promote preferred provider arrangements.</p>	<ul style="list-style-type: none"> • Need for Government to improve ambulatory care island-wide • Service providers should be familiarized with economic medicine
3. Inadequate awareness of the importance of health insurance retards the growth of the industry and restricts financial support for health care	Companies will promote this through the media	<ul style="list-style-type: none"> Government should make health insurance a minimum labor standard • Labor unions should make health insurance a basic benefit
4. Profitability of industry is low, as claims continue to increase as a share of premium.	<ul style="list-style-type: none"> • Introduction of cost constraint measures <ul style="list-style-type: none"> - improved monitoring - closer collaboration with health personnel - Promote use of generic drugs 	<ul style="list-style-type: none"> • Government's national drug policies should promote generic drugs

TABLE II - 13
(CONTINUED)

JAMAICAN HEALTH INSURANCE INDUSTRY:
MAJOR CONCERNS AND STRATEGIES IN PIPELINE AND REQUIRED SUPPORT

151

MAJOR CONCERNS	STRATEGIES UNDER CONSIDERATION	REQUIRED SUPPORT
<p>5 Insurance companies should be invited to devise a plan for the medical indigents</p> <ul style="list-style-type: none"> - it could help to reduce operating cost of other plans - it could help to reduce the central government cost of serving them 	<p>No specific strategies are planned for them. However, Blue Cross in particular feels it could introduce an innovative plan for them if it gets the required government support</p>	<ul style="list-style-type: none"> Government should determine the indigents by parish. Government should establish policy of financial support for health care to the indigent and work with the insurance industry to implement it
<p>6. Government's policy on private sector role in health care is unclear</p>	<p>No major strategies or initiatives are underway for the health insurance sector to become involved in health care services beyond being insurance carriers</p>	<p>Government needs to develop an adequate policy framework for the health sector. It should be designed to at least match the investment policy framework as exist in other sectors</p>
<p>7. HMO concept is retarded by abuse</p>	<p>The following strategies are under review:</p> <ul style="list-style-type: none"> - inclusion of more copayments by patients (only drugs and visits are presently copaid) - reduce the network of laboratories and pharmacies with whom they do business to make it more profitable for the competitive ones 	<ul style="list-style-type: none"> Technical assistance to promote the concept of HMO Government's promotion of the HMO concept

TECHNICAL ANALYSIS
 HEALTH INSURANCE INDUSTRY
 ANNEX D.2
 20

TABLE 11 - 13
(CONTINUED)

JAMAICAN HEALTH INSURANCE INDUSTRY: MAJOR CONCERNS
STRATEGIES IN PIPELINE AND REQUIRED SUPPORT

1291

MAJOR CONCERNS	STRATEGIES UNDER CONSIDERATION	REQUIRED SUPPORT
<p>8. Poor distribution of medical personnel and facilities in non-urban areas retards growth of health insurance industry</p> <ul style="list-style-type: none"> - adequate services cannot be guaranteed - secondary and tertiary care is hard to access 	<p>This is outside the direct control of the insurance industry.</p>	<p>Government policies are required to promote health facilities and retention of health personnel in non-urban areas.</p> <p>Government can pass legislation to sanction operation of rural clinics by nurse practitioners with scheduled visits by doctors. Preventative and diagnostic medicine outside of the hospitals</p>
<p>The quality of service in public facilities which accounts for over 80% of the service is poor. Therefore there is no drive to subscribe to health insurance.</p>	<p>None</p>	<p>Government should immediately involve the private sector to assist in improving the service</p>
<p>The health insurance industry will not grow as fast as it could due to the lack of pressure to have health insurance.</p> <ul style="list-style-type: none"> - The Private Sector role and services are very limited - The Public Sector which is more equipped to handle more complex cases charges very minimal fees. 	<p>None</p>	<p>Government should improve administration to ensure that the medical indigent get it free and others paid economic rates.</p>
<p>The health insurance sector does not enjoy any fiscal incentive for expanding their services</p>	<p>None</p>	<p>Government needs to broaden its investment from motion framework to include the health sector</p>

TECHNICAL ANALYSTS - HEALTH INSURANCE INDUSTRY ANNEX D.2

Both Blue Cross and Life of Jamaica are positive that their management "know how" are their key advantages in their proposed role, while Blue Cross highlights its international experience and network of services as well as its local dominance in the local health insurance market as key assets. Life of Jamaica indicates that its proposed role could greatly benefit from its management experience as well as its large financial reserve.

Mutual Life, which has a range of strategic plans for major expansion in health insurance has also expressed a strong interest in providing management support services to the public sector health care as an effort to increase private - public sector collaboration to improve the services. It is however not very clear regarding the specifics of the type of support Mutual Life could provide.

American Life (ALICO) and First Life would like to limit their role to insurance carriers in the Jamaican health care sector.

- ALICO feels that health care services are too complex, and risky. Besides, they are already engaged in Eureka Medical Complex.
- First Life also wants to limit its role to that of insurance carrier. It will however, reconsider its role if government introduces attractive incentives.

B. Projected Share of the Industry

Competition is likely to be very aggressive in the health insurance industry in the medium term as most of the carriers are aiming at significant growth in market share. For example, Mutual Life is planning to triple its share from 4.7% to 16.0%.

This optimistic outlook by each company, if aggressively pursued, is likely to generate a wider segmentation of the market and industry since each company will want to at least hold on to its present share of the business. Table 14 summarizes the 5-year outlook for the Jamaican health insurance industry.

**TABLE 14
 JAMAICAN HEALTH INSURANCE INDUSTRY: FIVE-YEAR OUTLOOK**

<u>COMPANY</u>	<u>PRESENT</u>	<u>PROJECTED</u>	<u>DRIVING FORCES</u>	
	<u>MARKET</u>	<u>MARKET</u>	<u>BEHIND PROJECTED</u>	
	<u>SHARE %</u>	<u>SHARE %</u>	<u>MARKET SHARE</u>	<u>MARKET STRATEGIES</u>
Blue Cross	52	60	Diversification of plans, inclusion of new markets.	Community involvement media promotion.
First Life	7	16	Specialized sales force with sales representatives being highly trained in health.	Media promotion of its specialized sales force.

TABLE 14 (CONT'D)

COMPANY	PRESENT MARKET SHARE %	PROJECTED MARKET SHARE %	DRIVING FORCES BEHIND PROJECTED MARKET SHARE	MARKET STRATEGIES
Mutual Life	4.7	10	Aggressive marketing	Restructuring of sales terms.
Life of Jamaica	2.2	35	Promoting wider participation in HMO	Promotion of the benefits of HMO.
American Life	15.2	No Projection		

Source: Insurance Companies

IV. CONCLUSIONS

Based on the analysis presented in this report, the following conclusions can be made.

1. About 14% of the Population have Health Insurance or other Arrangements for Third Party Payment for Health Care
 - . There are about 111,000 policy holders.
 - . There are about 333,000 insured.
2. Policy Holders are concentrated Among Those Involved in Large Establishments: The Civil Service, Financial Institutions, Commerce, and Manufacturing
 - . It is more cost-effective to administer these schemes.
 - . Employment is more stable in these areas.
3. The Large and Growing Informal Sector Representing over 350,000 Adults and 42% of the employed, is not Tapped by the Insurance Industry, even Though it Represents the Largest Segment of the Market
 - . The cost of servicing this segment of the market is prohibitive.
 - . They have no formal payroll system to facilitate easy collections.
4. The Growth of Insurance Industry is Slow
 - . The supply of private sector paid health care is limited.
 - . The fees charged by the public sector health care providers are not high enough to stimulate the need for health insurance.
 - . There are no quality differences between paid or free services in the public sector, the main provider, to stimulate the demand for health insurance.

5. Most Health Insurance Carriers have the Requisite Organizational Infrastructure to Expand in Health Insurance Services. They all Have the Following
 - . A market division.
 - . Actuarial services
 - . Claims division.
6. Only One Insurance Carrier, Blue Cross Provides Health Insurance Services Only
 - . Health insurance represents 1 to 24% of the business of other carriers.
 - . Blue Cross is the industry leader.
7. The Health Insurance Industry is very Competitive
 - . Premiums variations are in significant.
 - . The range of benefits and cash allowances under comparable plans are very similar.
8. Health Insurance Cash Allowance for Each Health Case far Exceeds the Fees Charged for the Service in the Public Sector, and is about 70% of the Fees charged by the Private Sector
 - . The unrealistically low fees in the public sector cushions the profitability of the health insurance industry.
 - . Public sector fees range from only 16% to a maximum of 38% of the fees charged by private sector providers.
9. Profitability of the Health Insurance Business is Relatively Low
 - . There is excessive use of health care services.
 - . The cost of drugs which accounts for 40% of claims has been rising at over 20% annually.
10. Health Insurance Companies have been Investing only in Low Risk Areas such as Government Securities and Real Estate Related Ventures
 - . About 43% of their investments are in Government's securities.
 - . About 33% of their investments are in real estate related ventures.
11. All Health Insurance Providers Plan to Expand their Levels of Business in the Future, Through:
 - . More aggressive marketing strategies.
 - . New and Innovative schemes.
12. Health Insurance Companies have no Interest in Long Term Investment in Health Services but could However collaborate with the Public Sector in the Following Areas:
 - . Management of the services.
 - . Promotion of health insurance.
 - . Management of cost containment in the service.
 - . Provision of coverage for the medically indigent.

13. There are about 8 Critical Issues Impacting on the Health Insurance Industry in the Following Ways:
- . The cost of health insurance to subscribers.
 - . The viability of the plans.
 - . The profitability of the plan.
 - . The growth of the industry.
14. Five Project Activities are Being Recommended to Address the Major Concerns Affecting the Industry as well as to Stimulate Collaboration with the Public Sector. They are:
- . Development of an execution of a health care scheme for the medically indigent.
 - . The development of a national drug procurement and pricing policy.
 - . The development and execution of a public education program designed for health care users, health care personnel, trade unions and employers.
 - . Development of the requisite policy framework for stimulating greater private sector collaboration with the public sector in health care.
 - . Appraisal of the potential for a National Health Insurance scheme.

ANNEX D.3. TECHNICAL ANALYSIS - PRIVATE SECTOR

Background: The Current Health Care System in Jamaica

The health care system in Jamaica is made up of a public and a private sector. Both sectors face a variety of problems, some of which are common to both and some of which are sector specific. This section summarizes the current status of the public health care system and presents a more thorough analysis of the private health care system. All tables and figures referenced in this section appear at the end of the section. Beyond the current status of the public and private systems, this section discusses the problems unique to the overburdened public health care system and the resources of the private sector that would complement the strengths, and alleviate the weaknesses, of the public health care system. Through a private/public partnership, Jamaica can realize the benefits of a decompressed public health care system.

The Public Sector

To date, the Jamaican public health care system has served as the primary source for health care financing and delivery for the entire island. The private sector of the island's health care system runs parallel to the public sector with similar system components: hospitals, clinical and laboratory services, health manpower resources (physician practices, nurses and allied health professionals), and health insurance (financing). Both the public and private sectors of the health care system have various strengths and weaknesses. The public system, however, is currently overburdened and has decreasing government support to meet the increasing needs of its patient population. This section outlines the problems unique to the overburdened public health care system.

Population Trends and Health Status

The public health care system is faced with many challenges in addressing the health care needs of the Jamaican population. The size of the Jamaican population was estimated to be approximately 2.5 million in the 1982 census, an increase of almost 1 million persons since 1962.^{1/} The distribution of the Jamaican population, as described in the Review of the Jamaican Health Sector and an Assessment of Opportunities for External Donor Support, is relatively even between the rural and urban areas of the island. Unfortunately, however, the health services resources are for the most part contained in the urban areas of the island and as a result, rural residents often do not have sufficient access to necessary health care. The resulting impact of the health care maldistribution or access problem resembles the health care maldistribution trend in the United States. When the rural patients, who are typically indigent patients, eventually access the public health care system, they typically enter at a progressed disease level requiring more medically sophisticated and technically intense treatment than they would have at an earlier stage of the disease. The impact of sicker indigent patients entering the system is increased health care cost to the public health care system.

Currently, the primary public health concerns for the island include infant mortality and malnutrition for children and cerebrovascular and cardio vascular diseases for adults. In 1984, the country's infant mortality rate was 13.2/1000 births 2/. Malnourishment and nutritional related deficiencies among children are also a

primary concern as a 1985 national survey of the nutritional status of children under age 10 found that 11.3% of children under age five had moderate to severe nutritional deficiency resulting in a national prevalence of stunting in children of that age group to be 7.1 percent ^{3/}. Maternal and Child health continues to serve as a main focus for the public health care system in its efforts to eradicate health problems related to malnutrition. As these efforts intensify the demand for public education and primary health, on a preventive basis, will continue to increase and the public health care system will require additional resources to meet this need.

Among adults, cerebrovascular disease was the number one cause of death occurring at a rate of 86.2/100,000 population in 1978 and heart diseases the number two cause of death occurring at a rate of 83.3/100,000 population during that same time period. The number three and four causes for death among adults are malignant neoplasms (80.1/100,000) and accidents (34.9/100,000) respectively ^{4/}.

The Review of the Jamaican Health Sector and an Assessment of Opportunities for External Donor Support, report also describes the population as relatively young and indicates that the over 65 segment of the population constitutes fifteen percent or lower of the total population. Although the report relates that in recent years there has been a shift in the disease, morbidity and mortality pattern, from infectious to chronic diseases, it is anticipated that as the population ages the trend to chronic and degenerative disease patterns will accelerate. As chronic disease prevalence increases, so will the public demand for technologically sophisticated diagnostic and clinical laboratory services as well as highly specialized physicians. To meet the increased need/demand for these services, the public sector will require additional resources to strengthen its current hospital system.

Public Hospitals

- Size of the sector: Prior to the rationalization of the public health care system, there was a total of 29 acute care hospitals on the island. In an attempt to reduce system redundancies and to create a more efficient system of care, there was a rationalization effort which involved the scaling down of the smaller underutilized acute care hospitals into primary care facilities and reducing the bed capacity of other acute care hospitals. As a result, the current capacity of the public health care system includes twenty-four hospitals and 447 primary health care clinics ^{5/}. The government remains the major provider of inpatient care for the entire island with private hospitals providing less than one percent of total inpatient admission ^{6/}. Yet the public hospital system as the primary provider of inpatient care for Jamaica is faced with several system deficiencies. Key system deficiencies include physical facility and equipment deficiencies, hospital management deficiencies, medical staff and nursing shortages, and clinical and diagnostic laboratory deficiencies. Following is a discussion of these deficiencies.

- Financial status: One of the primary problems facing the public hospitals is that of capital funding for facility maintenance and repair. Due to insufficient funding for maintenance, government hospitals are in severe disrepair. For example, according to the findings of a 1987 survey of eighteen physical facilities in each of the categories (A, B and C) conducted by the Pan American Health Organization and the World Health Organization, the average condition of the fixed equipment for all the hospitals surveyed was very low with an average rating of fifty on a scale of one hundred (with a rating of seventy-five being acceptable). Although this study reported slightly higher average ratings of the buildings, around sixty on a scale of one hundred, their ratings indicated that their condition

was still unacceptable (with ratings below seventy-five) 7/. As a result of this study, a Hospital Restoration Project was planned and IDB approval is pending.

Human Resources in the Public Sector

In addition to inadequate space, aging buildings and equipment, public facilities face human resource shortages. The following three contributing factors affect the human resource shortage situation:

- Poor working environment conditions, -- The disrepair of the physical facilities and equipment discussed in the preceding paragraph accounts in part for one of the contributing factors, poor working environment conditions. Lack of support personnel also contributes, in part, to the poor environment. Some private sector donor support in terms of additional equipment or capital funds to contribute to facility maintenance and repair could assist in alleviating the public sector working environment situation
- Inadequate training programs, -- Insufficient funding to provide additional medical training and management training represents one public system funding deficiency. As a result, in 1987 the MOH reported personnel vacancies, or shortages, averaging thirty-two percent for physicians (Grades I - IV), an average twenty-three percent in nursing vacancies, thirty-eight percent for Medical technicians, sixty-two percent for Radiographers, thirty-seven percent for Pharmacists, thirty-three percent for Physiotherapists and forty-five percent for Nutritionists/dieticians 8/.

An example of the impact that limited government funding for training has upon human resource shortages is the management training experience of the public health system. According to the government's five year plan, traditionally the Ministry of Health has placed over ninety percent emphasis on technical and professional training with less than ten percent on administrative and management disciplines. Due to the unavailability of funds, only about sixty percent of proposed training programs can be implemented due to lack of funds for traveling and subsistence for management staff in rural areas. Also eighty percent of the existing in-service training programs have no training manuals. As a result, the public health care system is in dire need of trained management personnel.

- Inadequate staff salaries -- Insufficient funding to attract highly trained and skilled health care managers as well as medical personnel (physicians, nurses and technicians) represents another. Low government salaries dissuade qualified personnel to fill government vacancies who instead either migrate or dedicate the majority of their services to the private sector of the health care system.

The public health care system is stressed due to reliance upon limited financial resources. The current system involves total reliance upon the government for reimbursement for the operating costs of providing health care. According to the government's five year plan (1987 - 91), the MOH is responsible for eighty percent of total health care financing. This total reliance upon the Consolidated Fund for financing is a result of little or no incentives for management innovation to secure alternative funding sources or to initiate system programs to maximize cost-effectiveness and reduce overall costs. For example, in 1987/88 the total revenues to the public health facilities was \$314.2M which represents a combination of government funding and annual fees collected from patients. Of that revenue, the

Government dedicated more than ninety percent of the total funds, or \$309.2M to the public health facilities 9/. An alternative reimbursement policy might involve the establishment of certain financial incentives that would encourage the public facilities to seek funding from alternative sources and implement cost-savings measures, such as improved collections on billings, that would benefit not only the government but the facilities.

Although the Ministry of Health's budget allocation, as a percentage of the total national budget, has remained stable at six percent, during the five year period from 1981/82 to 1985/86, the total expenditures for the Ministry of Health increased by \$104.3M, or 55.9 percent, from \$186.5M in 1981/82 to \$290.8M in 1985/86 10/. Moreover, health care accounts for 2.5 percent of the country's Gross Domestic Product (GDP). This rising cost of health care is particularly disturbing when care for the indigent is taken into account as the public hospitals carry the majority of the indigent care burden.

Sector Financing

Any discussion of reform of the public health care system involves addressing the financing and delivery of care to the indigent. In 1987 the Ministry of Health commissioned a survey of targeted catchment areas for pilot health care projects. Based upon the findings and recommendations of this study, "Appraisal of an Analytical Report on a Survey on New Initiatives in Health Finance and Administration" (the NIHFA Survey), the indigent population load for the entire island was estimated to be 1,041,000 indigents and 817,000 near-indigents. This segment of the population is estimated to be roughly 44.2 percent of the population (based upon estimates from the McFarlane Report on the NIHFA Survey). An additional 34.7 percent of the population is estimated to be "near indigent" 11/. The committee estimated the cost for providing care for this population to be \$299,924,000. However, through contracting with an experienced private sector health care or insurance organization, the government might realize a more efficient and cost effective system for financing and delivering care to the indigent.

Diagnostic and Laboratory Services

Clinical and diagnostic laboratory services in the public sector are also inadequate. The government's five year work program indicated that currently laboratory services are offered at the Government Medical laboratory in Kingston and at fifteen hospital laboratories throughout the island. However, the limited space to which the government laboratory is currently committed is unsuitable and is housed in an old complex not originally designed as a laboratory building. Moreover, often the government laboratory has been unable to provide necessary services due to staff shortages, equipment failures and inadequate supplies of reagents. Again, as is true throughout the public health system, inadequate salaries to attract trained professionals is the target of blame. At the time of the report the government estimated the cost for renovation and updating these facilities to be \$269,200.00. Steps have been taken to address this situation and public laboratory services should improve somewhat with the EEC funded construction of a new public laboratory. The new laboratory is scheduled for completion within one year.

Summary

In summary, the public health care system is faced with many problems and too few resources to adequately address these problems. An evaluation of the private sector, however, should reveal additional resources: financial, training and management expertise, and manpower, to address the health care needs of the island. This report will suggest, review, and evaluate various alternatives for potential "private/public partnerships" to strengthen and improve the Jamaican health care system.

The Private Sector

The Jamaican private health care system encompasses physicians, dentists, hospitals, diagnostic centers, laboratories, and private health insurance companies. Although the private health care system has been in existence for many years, its growth has been slow 12/. Utilization of private services, especially hospital services, is low when compared to the public sector. Reasons for limited private sector utilization and growth include the unavailability of equipment in the private sector, poor management of private facilities, limited private insurance coverage, and the government's reimbursement and regulatory policies.

The private health sector is not self-contained. Private sector providers are directly affected by several groups including associations and interest organizations, the government, and banks (See Figure 1). Also, as Figure 2 illustrates, there is interaction between the public and private sectors. The private health sector The

In spite of limited utilization of private services, the private sector serves a cross section of persons. A 1983 physicians' survey indicated that the majority of persons treated by private physicians were from the working class rather than the upper class (See Figure 3). Additionally, many persons who enter the private health care sector do not have third party insurance. The willingness of many persons to pay out-of-pocket for private services indicates that there is a large potential market for these services. Access to that market, however, is limited by services availability and persons' ability to pay.

The remainder of this section presents a review of the major components of the private health care sector, a brief analysis of current private/public initiatives, and a discussion of specific strengths that the private sector could offer to a public/private partnership.

Private Hospitals

- Size of the sector: There are seven private hospitals on the island, five of which are located in Kingston (See Table 1). All private hospitals function as secondary hospitals; the only tertiary care available is through either the University of the West Indies or the Kingston Public Hospital, both of which are public facilities. In addition to the seven private hospitals, private beds are available at several public hospitals 13/.

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162x

In the area of hospital care, the private sector has not been a major force. Total private sector admissions represent only about one percent of all admissions annually. The seven private hospitals range in size from ten beds to sixty-six beds with a total capacity of 286 beds. This represents only five percent of total beds available nationally. Services utilization is low largely because of the high costs of private care and the availability of comparable services through the public sector. For the most part, however, private sector services are considered to be of higher quality than public services. With increased insurance coverage, it is likely that the demand for private hospital services would increase.

• Financial status: All private hospitals are reporting some financial difficulty 14/. Occupancy rates are generally between fifty and sixty-five percent (See Table 1). It is generally accepted that occupancy rates of at least sixty to sixty-five percent are needed in order for hospitals to maintain financial health 15/.

Because of poor financial performance, heavy import taxes, and interest rates that average between twenty-four to twenty-seven percent, it is difficult for private hospitals to raise the capital necessary for the purchase and maintenance of up to date medical equipment. Therefore, certain services are not available through private hospitals. The unavailability of certain services has had a negative effect on the overall utilization of these hospitals.

Government policies regarding duties on imported medical equipment have had a particularly damaging affect on private sector growth. There are four types of duties applied to equipment and supplies imported into Jamaica. Those duties are import duties, consumption duties, custom duties, and stamp duties. In its Ministry Paper #48, the GOJ modified the import duty obligations of private hospitals. As of December 16, 1988, the aggregate custom and stamp duty on imports of medical and scientific equipment was reduced from thirty percent of equipment purchase price to twenty percent of price. While this action represents a reduction in the tax burden on private medical enterprises, duty taxes continue to be an impediment to sector growth. For example, with the purchase of ultra-sound equipment for J\$ 230,000 (U.S. \$ 47,000), one facility reported that the stamp duty applied equaled J\$ 49,000. Figure 4 provides examples of the duty rates applied to items frequently purchased by private health care facilities and laboratories. Such high tax rates have led many institutions to indefinitely postpone purchases of new equipment thereby limiting services availability throughout the private sector.

Beyond the unavailability of certain services in the private sector, the government's reimbursement policies and the limited availability of third party insurance coverage have affected private hospitals' ability to grow financially. Basic care received through private facilities averages J\$ 250 daily. Drug and accessory costs are in addition to the basic care charge and average J\$ 550 daily (See Table 1). With government funded care available through public hospitals; those seeking care in costly private facilities are generally the wealthy or persons with private health insurance. Even those with third party coverage often turn to public facilities for inpatient care because insurance copayments for private care generally exceed the cost of care in a public facility 16/. Additionally, there is no mechanism through which private hospitals can receive payment for care rendered to indigent or low income persons. Therefore, when private facilities serve persons who are unable to pay, the cost of care is classified as "bad debt".

Beyond problems encountered when dealing with the uninsured patients, private hospitals often experience financial difficulty when dealing with persons

covered by private insurance. Private hospitals report that they experience problems when dealing with third party insurers. Many private hospitals report delays in collecting fees and difficulties in establishing proper user fees.

● Specific problems facing private hospitals: Overall, private hospitals' difficulties fall into the categories of human resources, management, and finances.

As with public facilities, private hospitals have had difficulty attracting and retaining adequately trained staff. The private sector's problems with staff recruitment and retention mirror the difficulties experienced in the public sector. The island lacks training programs for hospital administrators and other management level personnel in the health care field. Therefore, hospital management is not sufficiently equipped to deal with the problems facing the private health sector. Inadequate management training has led to poor resources allocation, inadequate planning, and improper or nonexistent management controls and ultimately affects private hospitals' financial position 17/.

Private hospitals' manpower deficiencies extend beyond the dearth of trained management personnel. Hospitals have difficulty recruiting adequately trained nurses and technical and ancillary staff personnel. Private sector pay for nurses, while slightly higher than in the public sector, is below what those nurses could earn elsewhere. Given the nursing shortage in the United States, many trained nurses accept positions abroad. Additionally, there are no programs in place to properly train technical and ancillary staff to operate recently developed medical equipment.

The management problems facing private health/medical practitioners are, to a large extent, the direct result of the lack of trained management personnel discussed above. Because management is frequently unfamiliar with the unique aspects of the health care sector, in many private hospitals major management decisions are made by staff physicians who lack management training 18/. The result of this management vacuum has been poor to nonexistent long term financial and strategic planning, inadequate or poorly designed marketing programs, and poor resources management and allocation. These management shortcomings have affected the ability of private sector hospitals to perform in the market place and to develop innovative strategies for increasing their market share.

The major financial problems facing private sector hospitals fall into the following categories: (1) difficulty in obtaining proper reimbursement for care rendered, (2) problems in raising capital due to poor cash flow, (3) high interest rates, and (4) heavy taxes on imported equipment. Many of these problems are discussed in detail in the preceding section.

With only a small percentage of the population covered by private health insurance, there is a limited market for private hospital services. In light of the fact that public sector hospital services are paid for by the government, it has been difficult for private hospitals to access all of their potential market. This failure to attract large numbers of patients, combined with an inability to receive reimbursement for care rendered to indigent and low income persons, has resulted in financial shortfalls and an accompanying inability to raise capital to finance services expansion. It is important that reimbursement policies be examined and possibly restructured so that both the public and private sectors are able to pay for costly equipment, drugs, and staff that is necessary to the provision of care.

Sector Financing: Health Insurance

● Size of the sector: There are five key health insurance providers (see Table 2). Four of these companies offer indemnity insurance plans that pay providers as services are rendered to insurance subscribers. The fifth provider is a health maintenance organization (HMO), HMO Jamaica, which is a wholly owned subsidiary of Life of Jamaica. HMOs differ from indemnity insurance plans in that they pay participating service providers a set monthly fee (capitation rate) per subscriber. This fee does not vary over the course of the provider's contract term regardless of the cost of services that the provider renders to a given subscriber. In addition to these five insurance providers, several larger companies such as the Jamaican Telephone Company and the National Commercial Bank self-insure. In general, services covered by private health insurance include physician services, hospitalization, and pharmaceuticals. There is very limited coverage of dental services 19/.

Table 3 shows the market share of each insurance company in Jamaica. Blue Cross has the largest market share, insuring fifty-two percent of those persons with private health insurance coverage. Other large firms are First Life and ALICO, each with over ten percent of the market. While HMO Jamaica has a relatively small market share, its volume, both for subscribers and participating physicians, has increased dramatically over the past year 20/.

An estimated fifteen percent (15%) of the population is covered by private health insurance. This represents an increase in private health insurance coverage from 12.7 percent of the population in 1981 21/. This increase has been due largely to the fact that more employers have begun to offer health insurance as an employee benefit. At the present time, it is estimated that nearly all of the unionized work force has some form of employer provided coverage 22/. The growth of employer provided insurance benefits has been aided by favorable tax treatment of employer insurance contributions 23/.

In spite of recent increases in the number of persons covered, it is estimated that the private health insurance industry reaches only a portion of its potential market. Major impediments to growth in the use of private insurance include a lack of consumer education regarding the purpose or advantages of private insurance, difficulties in marketing to certain sectors of the economy such as self-employed and seasonally employed persons, and the availability of government funded health care. Additionally, some researchers have stated that insurance companies' fee structure limits market growth. Because small groups and individuals are charged higher premiums than larger groups, the attractiveness of health insurance to those employers is limited 24/.

As Figure 5 illustrates, nearly all insurance claims paid are for physician services and pharmaceuticals. Private insurance coverage has had little effect on the finances of public hospitals. There are several reasons for this. Until recently there was little incentive for public hospitals to pursue insurance collections. Fees collected were returned to the Consolidated Fund rather than retained at the site of collection. In 1985, regulations were changed to allow public health facilities to retain fifty percent of the fees they collected. Since that time, there is evidence that fee collection among public facilities, including collections from health insurance companies, has improved 25/.

Beyond collection difficulties, public facilities have problems identifying those persons with private insurance coverage. Reasons for this include the fact that services will be paid for regardless of coverage and there appears to be a general lack of understanding regarding the purpose of health insurance. One study points to instances where persons with private coverage concealed that fact from public facilities where they were receiving service; services were paid by the government and the insured then submitted claims to the insurance company and kept the money 26/. Even when public facilities can identify an insured patient, service charges are heavily subsidized by the state; amounts billed to the insurance company are usually far below costs.

● Financial status: Some insurance companies, most notably HMO Jamaica, are reporting financial difficulty. Representatives from most, however, share a positive industry outlook, predicting increased enrollment and a growing role for private insurance in health care delivery 27/. The financial difficulties reported have many causes, including low enrollment and poor provider controls.

Low enrollment means that, among other things, there is an inadequate base across which to spread the risk of insuring against unforeseen and costly illnesses. When the number of covered persons is low, one catastrophic illness can have serious consequences for the company. Therefore, rates must be adequate to protect the insurance companies from the financial difficulties that they would face should some subscribers experience catastrophic illnesses. Current rates range in the area of J\$ 37.37 (individual) to J\$ 104.99 (family) monthly which is beyond the reach of most persons absent some form of employer contribution 28/.

For the most part, the insurance companies examined have poor controls over provider utilization. While some report that they have developed "Utilization Review" boards for the purpose of determining which physicians may be over-utilizing services or providing inappropriate services, in most cases companies have a limited role in monitoring and correcting participating physicians' practice patterns 29/. Additionally, many companies report difficulties in negotiating reduced rates with specialists or in getting physicians to comply with referral form requirements. Increased participation by physicians in referral and utilization control systems will reduce overall health care costs for insurers.

While the company representatives interviewed presented a positive outlook for the future, physician and medical group representatives commented on insurance companies' generally poor performance. Many physicians interviewed stated that insurance reimbursement was slow and that many services were not covered. It was reported that several providers have ceased to deal directly with some insurers because of payment delays.

● Specific problems facing the insurance industry: Insurance companies face problems marketing to consumers and controlling costs through proper physician monitoring mechanisms. Both of these problems have financial ramifications for the private health care system. Failure to access markets leads to low plan enrollment and either eventual financial failure or the need to set rates beyond the reach of most consumers and employers. Inadequate physician monitoring often results in unnecessary services utilization, poor quality control, and redundant charges. In spite of these problems, however, it appears that overall management of insurance organizations exceeds management of private hospitals.

Health Manpower in the Private Sector

- Number of Physicians in Private Practice: Physicians in private practice constitute the largest element of the private medical sector. While the number of physicians and dentists practicing in Jamaica is not accurately known, 1986 MOH estimates placed 420 physicians wholly in private practice. That represented fifty-three percent of the estimated 786 physicians practicing at that time 30%. In addition to those physicians wholly in the private sector, many doctors working in the public sector engage in private practice.

- Financial status: Unlike other elements of the private sector, private physicians' volume is sufficient for their practices to succeed financially. Physician shortages at PHC clinics, drug shortages within the public sector, and long waiting times at public clinics and outpatient facilities contribute to persons' willingness to use private physicians.

While payments to physicians represent a large percentage of total insurance payments, many persons who elect to see private physicians do not have insurance coverage 31%. Charges for private consultation are estimated to range from J\$ 40 to J\$ 80 depending upon specialty. This cost is modest when compared to private hospital charges shown in Table 1. Many persons appear to be willing to pay such modest charges out of pocket in exchange for what is perceived to be higher quality service. If hospitalization becomes necessary, those uninsured who receive private physician care generally turn to public hospitals.

- Specific problems facing physicians in private practice: While there are problems facing physicians in private practice, such as delays in insurance payments, generally, physicians in private practice are better off than their counterparts in the public sector. Public sector pay is quite low and, given patients willingness to pay for private physician services, the financial rewards of private practice can exceed those of public service.

Diagnostic and Laboratory Services

- Size of the sector: There are fewer than five private diagnostic and laboratory centers in Jamaica. These centers, however, offer specialized services that are not available or are available on only a limited basis through the public sector. The ownership of these centers varies. One center is a joint venture between physicians, an insurance company, and an entrepreneur. Regardless of ownership, these facilities are designed to operate as profit centers.

Although most diagnostic centers and laboratories have grown in recent years in terms of equipment acquired, most report that they need much additional equipment. Generating sufficient capital for major purchases, however, is difficult. As illustrated in Figures 6 and 7, laboratory and diagnostic centers' operations are generally well below capacity. Persons served by diagnostic centers are usually referred by private physicians. Payment sources as reported by one center are private insurance companies (31%), self-pay (27%), and employer contracts (42%). Because centers' services are not marketed to users of public sector hospitals or health centers, their potential market is quite limited.

- Financial status: Many private centers report the need for additional cash flow. Financial difficulties stem from an inability to generate adequate patient

volume and added fees that must be paid on equipment purchases in the form of duty.

Representatives from diagnostic centers and laboratories report that volume is low for several reasons. Often physicians are not trained in the use of new diagnostic tests. Therefore, they are reluctant to refer patients to the centers for testing or they do not know when certain tests would be appropriate. As with private hospitals, this section of the private medical sector has also been adversely affected by the lack of third party coverage and reimbursement for indigent care. Diagnostic and lab tests are costly and, because the government does not pay for services rendered through these private facilities, many persons can not afford the services of these centers.

Heavy taxes have hampered centers' growth. Unlike private hospitals, diagnostic centers do not receive duty tax exemptions and, as illustrated in Figure 4, duty can comprise a substantial portion of the purchase price of diagnostic equipment. These high taxes on imported medical equipment have had a negative impact on centers' ability to purchase new equipment. Eureka Medical Center provides an example of the currently heavy import tax obligations that centers face. On recent purchases of a cat scanner and ultra sound and x-ray equipment, Eureka owed J\$ 1.4 million in duty. That J\$ 1.4 million charge represents a twenty-five percent discount on customary duty fees.

High interest rates have also hindered centers' ability to expand. At the time of this writing, diagnostic centers were reporting twenty-seven to twenty-nine percent interest rates on loans. Centers must charge high fees in order to finance loans and to recover equipment taxes and purchase price within an acceptable time period. These high prices further drive down patient volume.

While many centers report that they are not generating profits on their medical testing, some have undertaken innovative steps to improve their financial status. For example, in order to provide additional cash flow and to generate patient volume, one diagnostic center rents office space to private physicians. These physicians, in turn, send most of their referrals for testing to the center from which they rent.

- Specific problems facing private diagnostic centers and labs: The most serious problems facing these centers are the financial problems outlined above. Centers' efforts to educate physicians on the use of new diagnostic equipment have been marginally successful. Many physicians continue to refer private-pay patients to Miami when diagnostic tests are needed even though those tests are now available through private diagnostic centers.

Volume for many centers is far below what was anticipated at start-up. Four factors account for low center volume: (1) because the government will not pay for services rendered at private diagnostic centers, low-income and indigent persons are not able to access those centers; (2) because of a lack of familiarity with new tests and procedures, physicians' often fail to refer patients for beneficial and cost effective tests or they continue to refer patients to Miami for diagnostic testing; (3) the limited use of private insurance has reduced the number of persons who can afford private medical testing; and, (4) high interest rates and taxes on imported equipment are severely limiting the ability of private centers to acquire current technology and are forcing centers to charge high prices to recover equipment costs.

Strengths that the Private Sector Can Offer to a Public/Private Partnership

Although the private health care sector faces many challenges, it offers many strengths that are not readily available in the public sector. Unlike the public sector, the private sector is goal oriented; it focuses on efficiency and profitability. Its emphasis on efficiency and profitability provides opportunities for improved management techniques and enhanced patient care coordination that could not only lower costs but also increase the quality of care delivered. Additionally, components of the private sector can bring management expertise to the public sector. Specifically, insurance companies offer management and health care financing skills that are lacking in the public sector. Many insurance companies can also call on overseas affiliates to provide managerial and technical assistance in program operations.

In light of the current financial difficulties experienced by many private sector concerns, there was a great deal of interest expressed in exploring opportunities for the public and private health care sectors to work together. As Figure 1 illustrates, these centers already interact to some extent. Public/private partnerships should draw on these existing areas of interaction and create new opportunities for inter-sector cooperation.

In Jamaica the private sector has already assumed a role in assisting the public sector to reduce costs and increase efficiency in several areas of the economy. Within the health care sector, at some public hospitals janitorial services have been contracted out to a private management company with reported success. In other areas, street cleaning services have been delegated to private firms. This has resulted in both improved services and reduced costs to the government.

The remainder of this report explores opportunities for the public and private health care sectors to work together in an effort to improve the overall cost effectiveness and quality of the Jamaican health care system.

TABLE 1.

Private Hospitals in Jamaica and Number of Beds

<u>Hospital</u>	<u># of Beds</u>	<u>Occupancy Rate</u> 1/
St. Josephs Memorial	66	57%
Medical Associates	64	66.5%
Hargreaves Memorial	55	48%
Nuttall Hospital	44	70%
Andrews Memorial	33	60%
Maxfield Medical Centre	14	59%
Doctor's Hospital	10	65%

1/ Occupancy rate information for all hospitals except Maxfield was obtained by the USAID office from each hospital. The rate for Maxfield is estimated based on average occupancy rates for the other six hospitals.

Hospital Average Daily Charges:

Room, Board, Nurses:	J\$ 250	US\$ 46.64
Drugs and Accessories:	J\$ 550	US\$ 102.61

Source: Medical Associates Hospital. Conversion from Jamaican to U.S. currency is calculated at the rate of US\$ 1 = J\$ 5.36.

170x

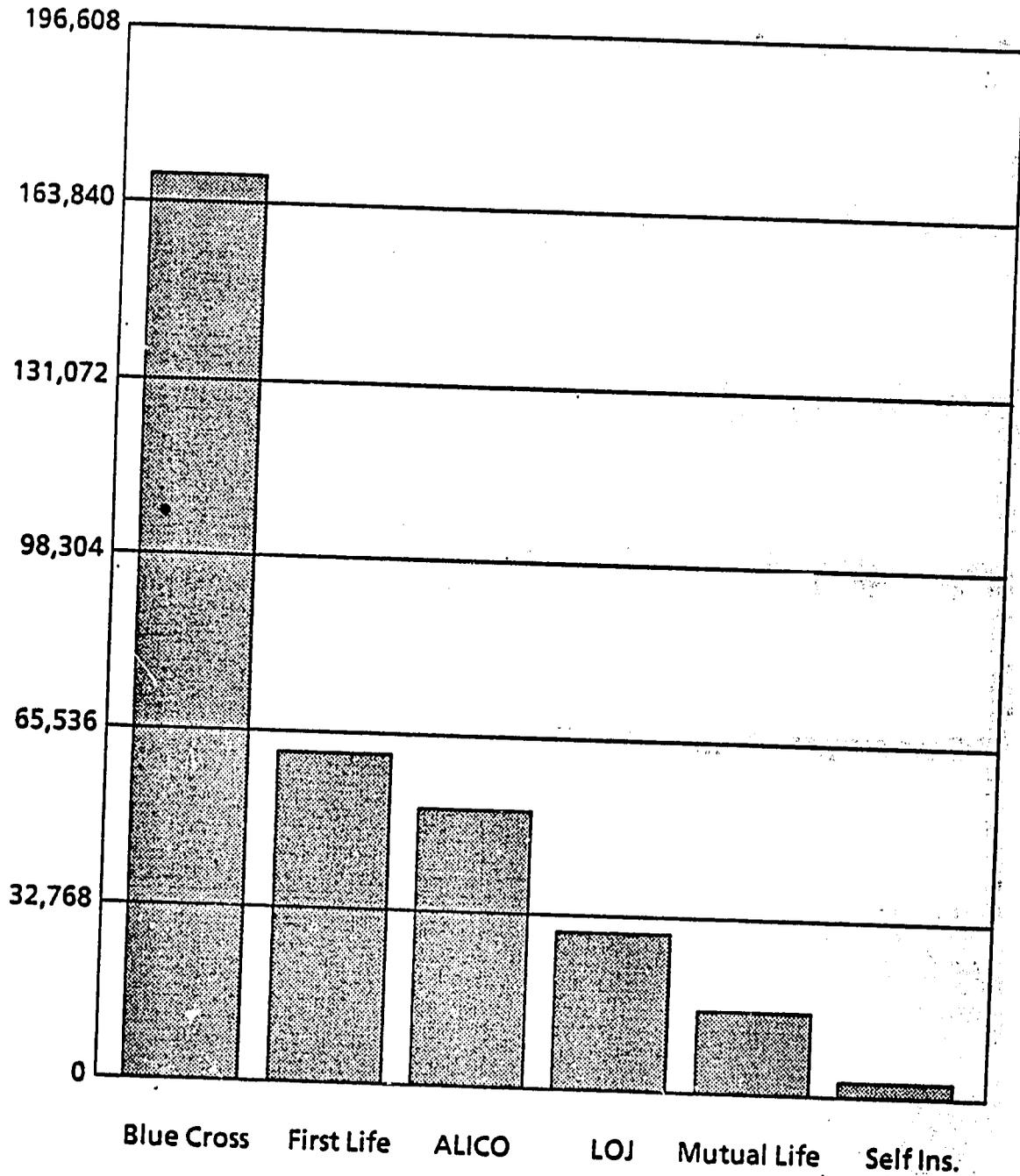
TABLE 2.

Private Health Insurance Companies in Jamaica

- Blue Cross of Jamaica
- First Life
- The Jamaica Mutual Life Assurance Society
- American Life Insurance Company - Jamaica
- HMO Jamaica, wholly owned subsidiary of Life of Jamaica

Source: HSMD.

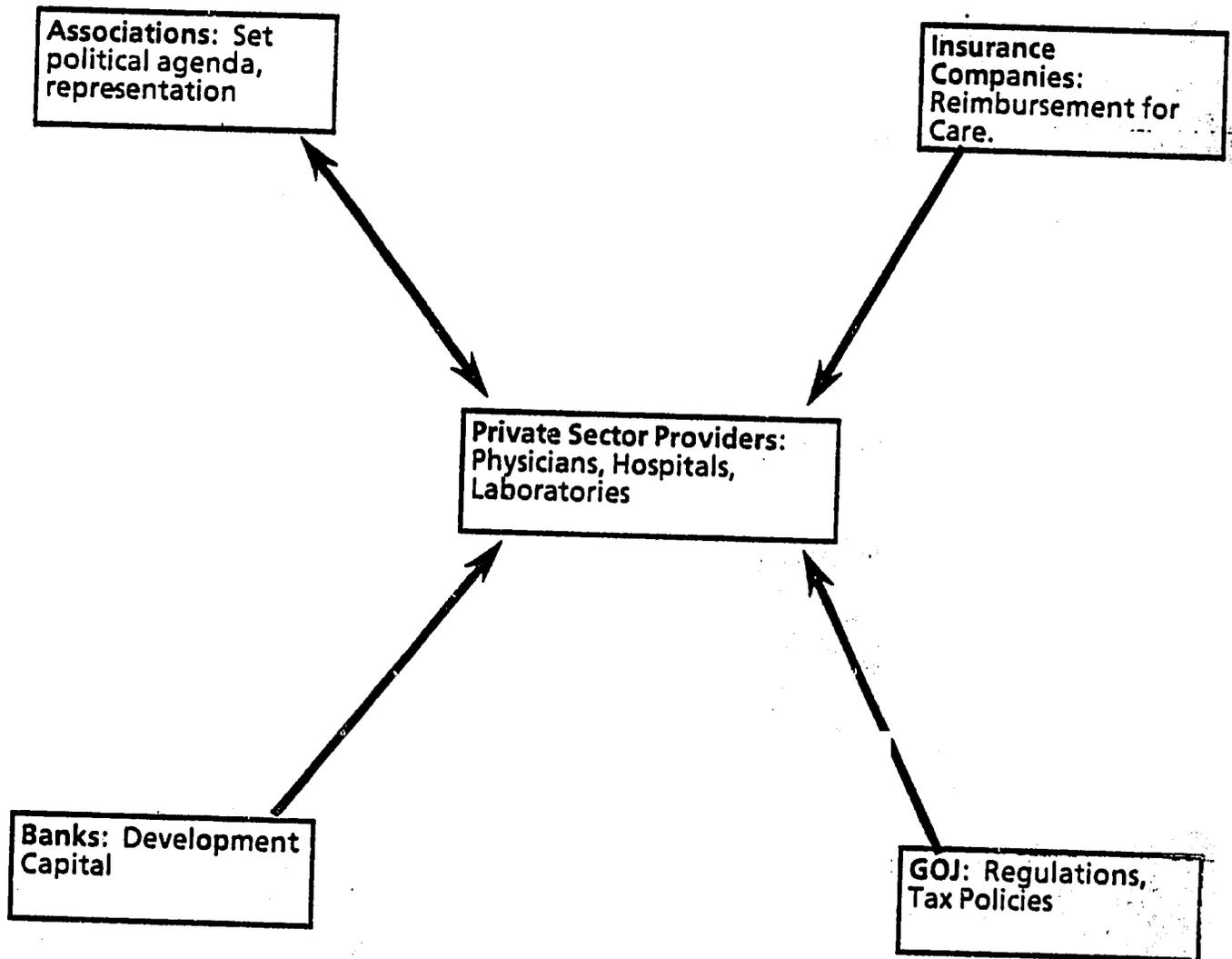
TABLE 3.
Jamaica: Insurance Providers and Market Share HSMD



Based on data from Blue Cross Jamaica; American Life Insurance Company, Jamaica; HMO Jamaica; and, Trevor Hamilton and Associates, "A Review of the Health Insurance Industry and Public Health Services in Jamaica," November 29, 1988. Data based on estimated number of persons insured.

172x

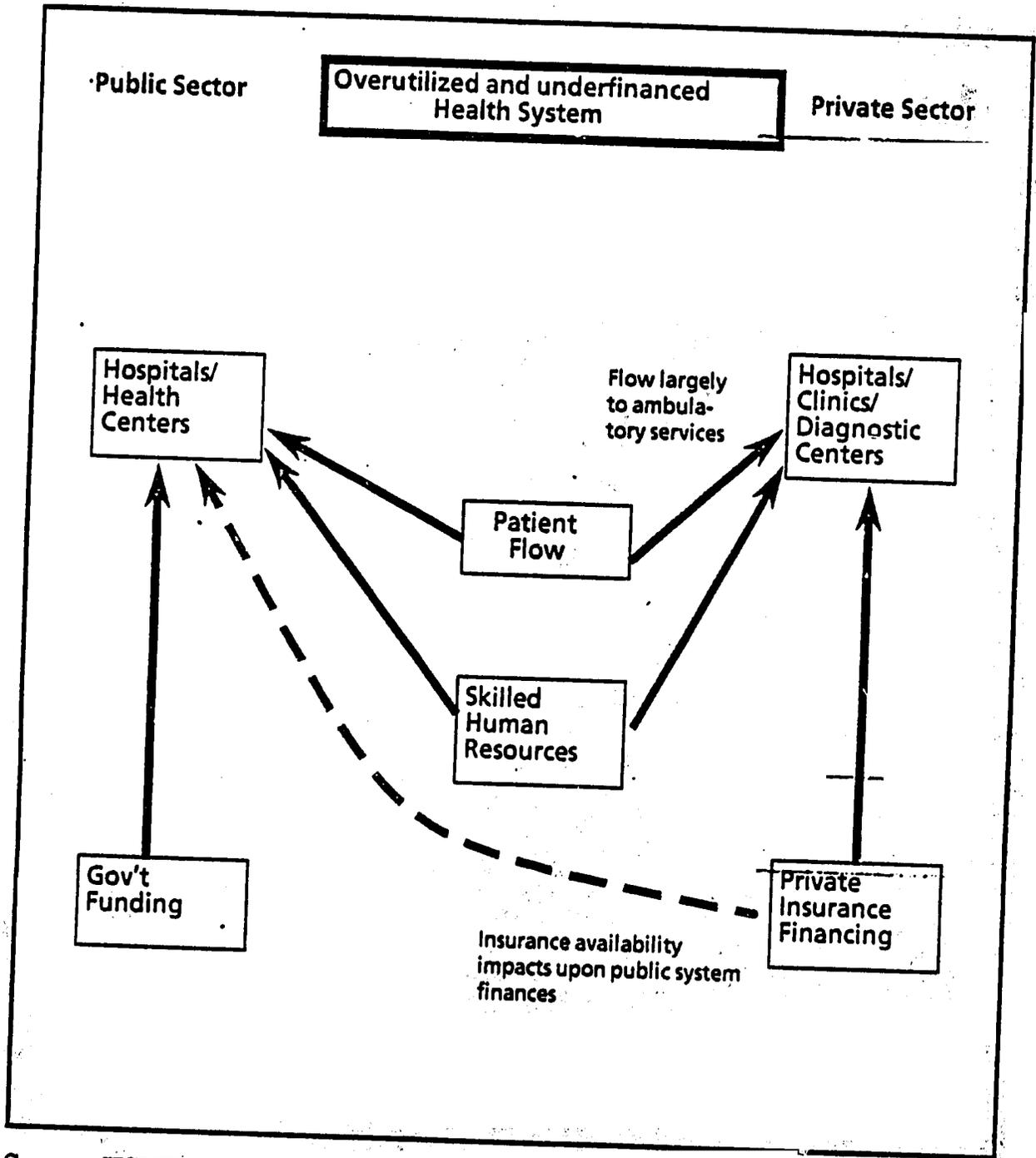
FIGURE 1.
Organizations Directly Interacting With Private Health Care Providers



Source: HSMD.

FIGURE 2.

Interaction of Public and Private Health Care Sectors in Jamaica: Opportunities for a Public/Private Partnership.

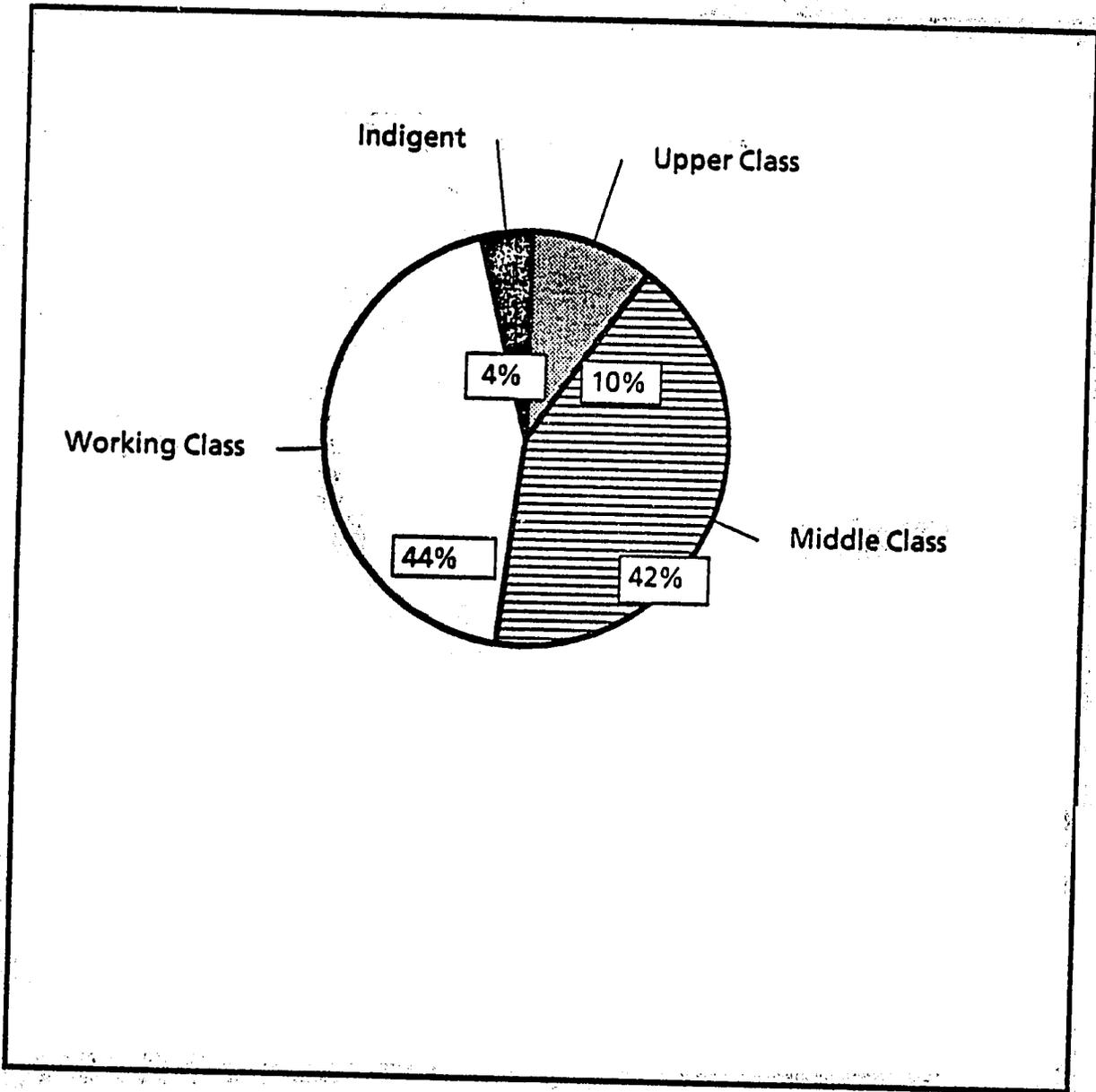


Source: HSMD.

1744

FIGURE 3.

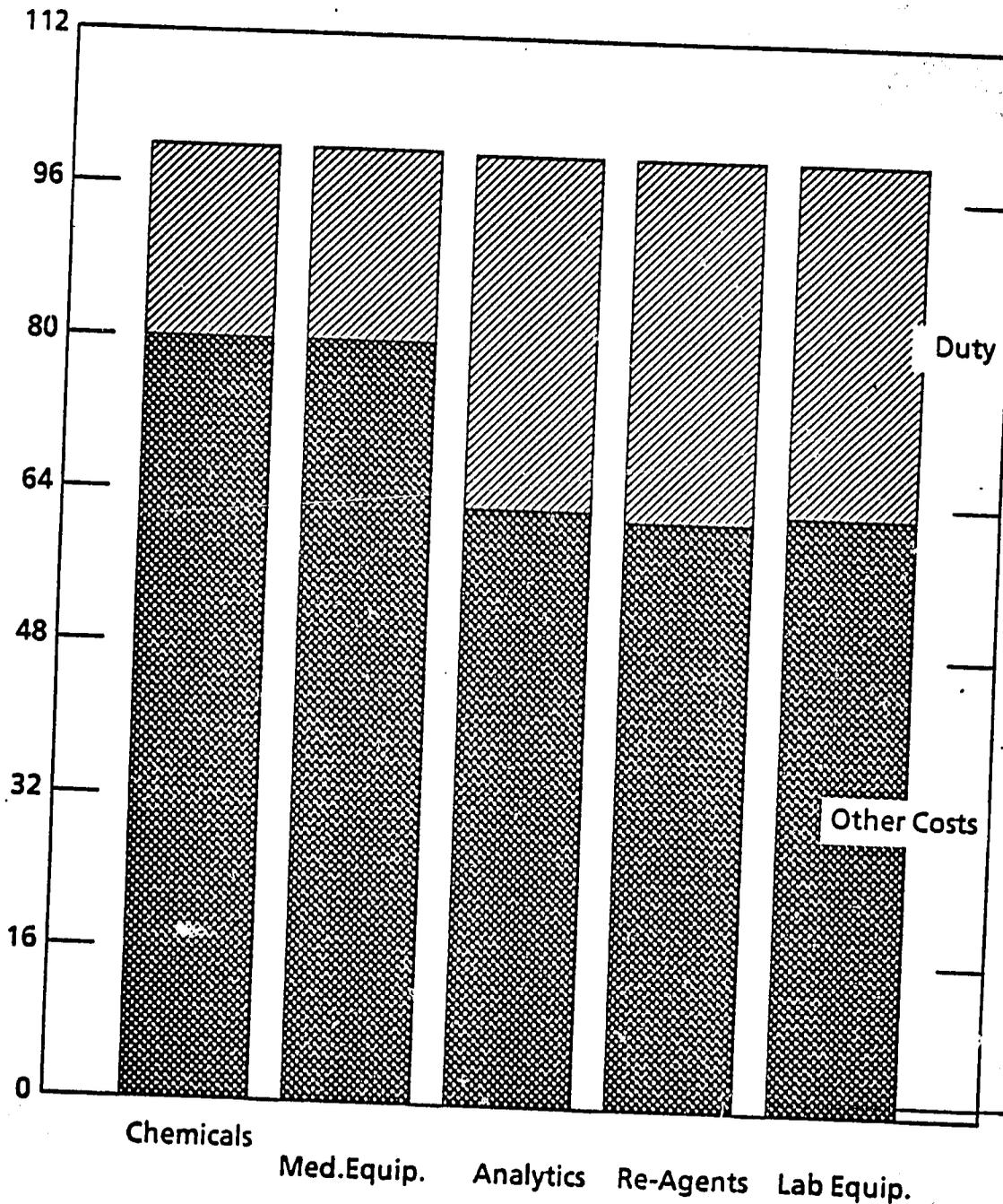
Social Class of Private Patients as Reported by Physicians, 1983.



Source: HSMD based on data reported in the 1983 "Physicians' Survey." by Joan M. Rawlins and Winsome A. Segree, USAID

-19-
FIGURE 4.

Duty as a Percentage of the Total Purchase Price of Medical Equipment and Supplies for Private Hospitals and Medical Centers

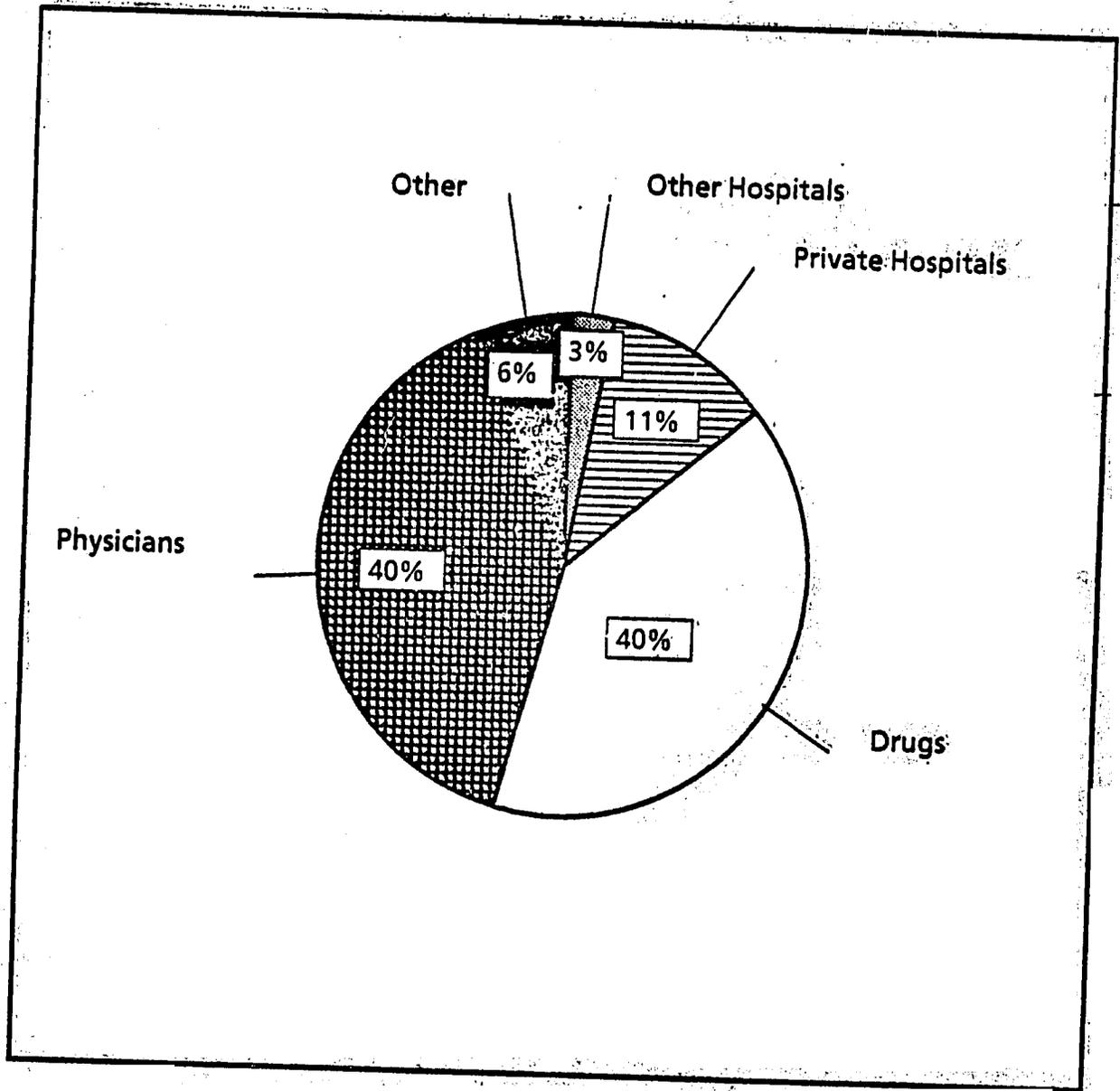


Source: HSMD based on data from Biomedical Labs (data on chemicals, lab equipment, re-agents, and analytics) and Eureka Medical Center and Medical Associates.

176x

FIGURE 5.

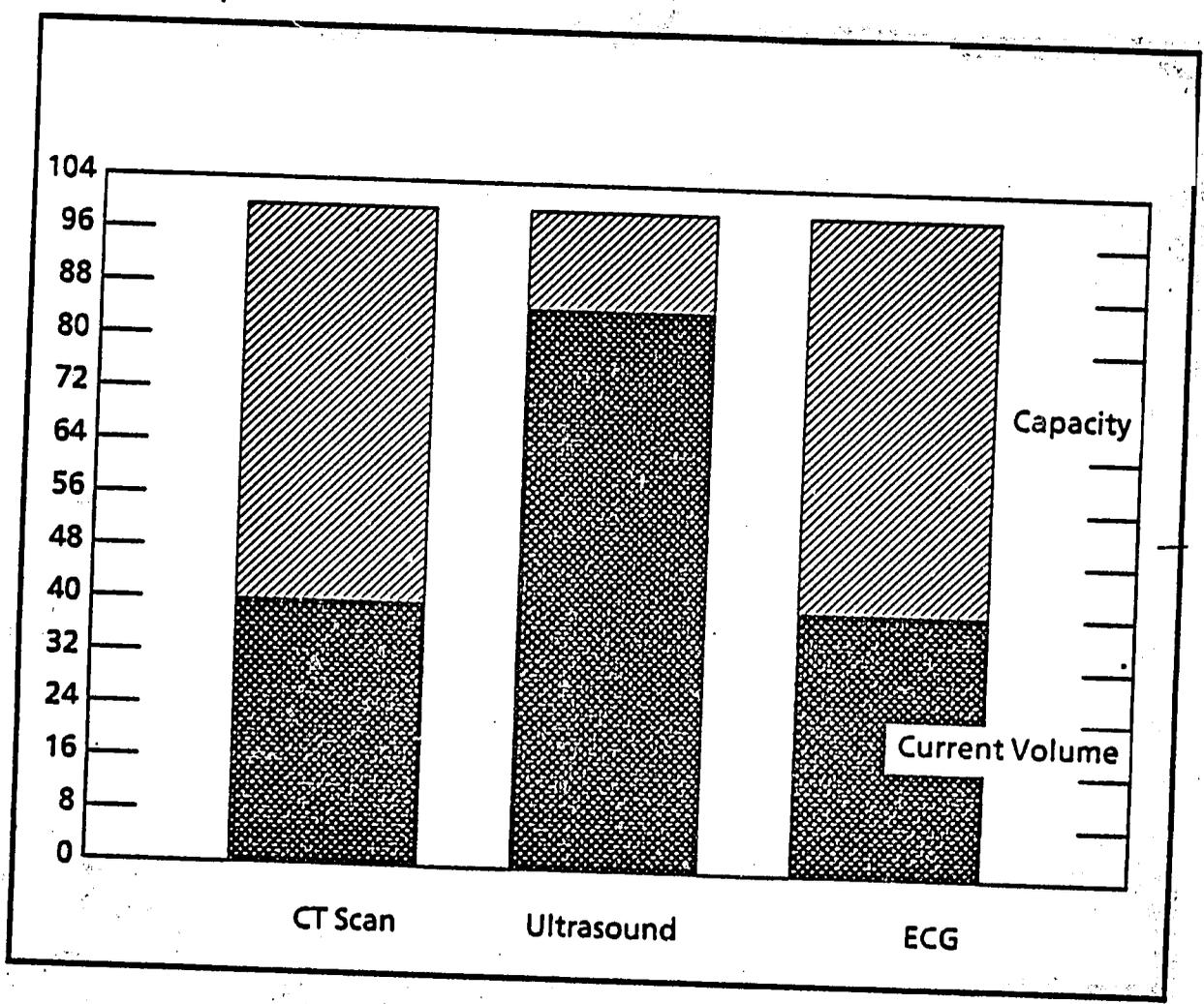
Private Health Insurance Payments by Claims Submitted



Source: HSMD based on data from J. Kutzin, "Analysis of Private Health Insurance in Jamaica," Project Hope (May 17, 1988).

-21-
FIGURE 6.

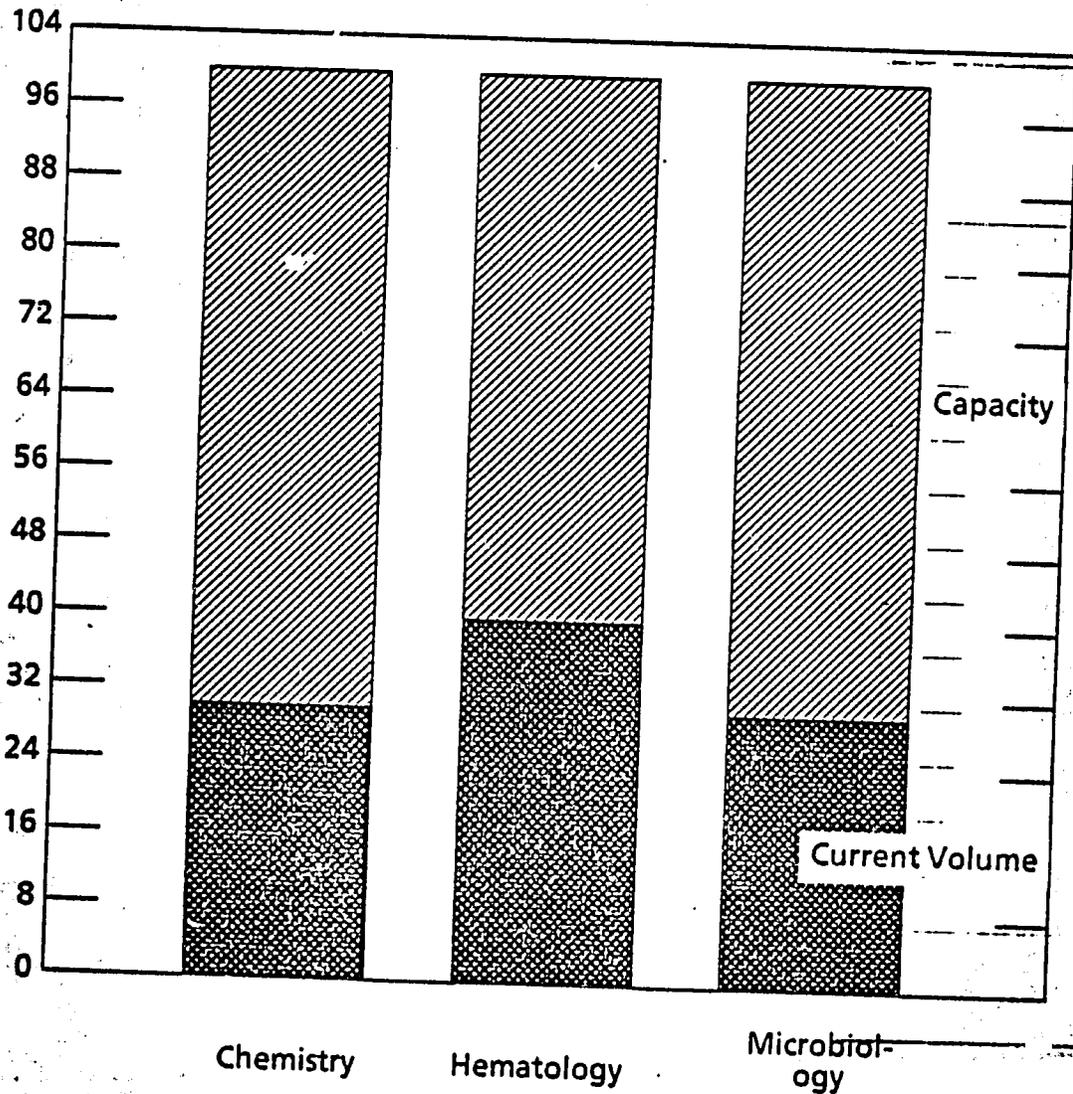
Average Private Diagnostic Services
Current Volume Compared to Capacity: Selected Services



Source: HSMD based on data from Eureka Medical, LTD.

FIGURE 7.

Average Private Laboratory Services
Current Patient Volume Compared to Capacity: Selected Services



Source: HSMD based on data from Biomedical Laboratories.

FOOTNOTES

- 1/ Sweezy, Curtis; Joel Greenspan; and, Larry Forgy. Review of the Jamaican Health Sector and An Assessment of Opportunities for External Donor Support. (Technologies for Primary Health Care Project, October, 1987).
- 2/ Sweezy, Curtis; Joel Greenspan; and, Larry Forgy. Review of the Jamaican Health Sector and An Assessment of Opportunities for External Donor Support. (Technologies for Primary Health Care Project; October, 1987).
- 3/ Sweezy, Curtis; Joel Greenspan; and, Larry Forgy. Review of the Jamaican Health Sector and An Assessment of Opportunities for External Donor Support. (Technologies for Primary Health Care Project; October, 1987).
- 4/ Pan American Health Organization. Health Conditions in the Americas, 1981-1984- Volume II, (Washington, D.C. 1986).
- 5/ Lewis, Maureen. Financing Health Care in Jamaica: Draft (June, 1988): Pan American Health Organization, Hospital Restoration Project; Interim Report, PAHO, (April 1987).
- 6/ Pan American Health Organization, Hospital Restoration Project; Interim Report, PAHO, (April 1987).
- 7/ Health Management & Financing Committee Report, (September 26, 1988).
- 8/ Sweezy, Curtis; Joel Greenspan; and, Larry Forgy. Review of the Jamaican Health Sector and An Assessment of Opportunities for External Donor Support. (Technologies for Primary Health Care Project, October, 1987).
- 9/ Health Management & Financing Committee Report (September 26, 1988).
- 10/ Sweezy, Curtis; Joel Greenspan; and, Larry Forgy. Review of the Jamaican Health Sector and An Assessment of Opportunities for External Donor Support. (Technologies for Primary Health Care Project, October, 1987).
- 11/ Health Management & Financing Committee Report, (September 26, 1988).
- 12/ In a recent study of the Jamaican health sector, it was determined that private sector utilization, as measured by discharges from private hospitals, had not increased from 1975 to 1985. There is no data indicating that utilization of private sector hospitals has increased from 1985 to the present. (Curtiss Sweezy; Joel Greenspan; and, Larry Forgy. Review of the Jamaican Health Sector and An Assessment of Opportunities for External Donor Support. Technologies for Primary Health Care Project, October, 1988).
- 13/ Sweezy, Curtis; Joel Greenspan; and, Larry Forgy. Review of the Jamaican Health Sector and An Assessment of Opportunities for External Donor Support. (Technologies for Primary Health Care Project, October, 1987).
- 14/ Stevens, Carl. Alternatives for Financing the Demand for Health Services in Jamaica (May 12, 1983).

- 15/ Stevens, Carl. Alternatives for Financing the Demand for Health Services in Jamaica (May 12, 1983).
- 16/ Project Hope, Analysis of Private Health Insurance in Jamaica, May, 1988, Hamilton, Trevor and Associates, Progress Report on A Review of the Health Insurance Industry and Public Health Services in Jamaica (November 29, 1988).
- 17/ The detrimental effects of poor management training on one private hospital's overall performance was well documented in Trevor Hamilton and Associates's September, 1987 management analysis of Medical Associates Hospital.
- 18/ Hamilton, Trevor and Associates, Management Analysis of Medical Associates Hospital (September, 1987).
- 19/ Hamilton, Trevor and Associates, Progress Report on A Review of the Health Insurance Industry and Public Health Services in Jamaica (November 29, 1988).
- 20/ HMO Jamaica reports that enrollment nearly doubled in the period August 1987 to August 1988. During that same time period, the plan reported a one-third increase in provider participation.
- 21/ Hamilton, Trevor and Associates, Progress Report on A Review of the Health Insurance Industry and Public Health Services in Jamaica (November 29, 1988); Sweezy, Curtis; Joel Greenspan; and, Larry Forgy. Review of the Jamaican Health Sector and An Assessment of Opportunities for External Donor Support. Technologies for Primary Health Care Project; October, 1987.
- 22/ American Life Insurance Company of Jamaica.
- 23/ Project Hope, Analysis of Private Health Insurance in Jamaica, May, 1988.
- 24/ Project Hope, Analysis of Private Health Insurance in Jamaica, May, 1988, Hamilton, Trevor and Associates, Progress Report on A Review of the Health Insurance Industry and Public Health Services in Jamaica (November 29, 1988).
- 25/ Lewis, Maureen. Government Policy and the Effectiveness of User Charges in Jamaican Hospitals (October, 1988); Project Hope, Analysis of Private Health Insurance in Jamaica (May, 1988).
- 26/ Project Hope, Analysis of Private Health Insurance in Jamaica (May, 1988).
- 27/ Interviews with representatives from several insurance companies.
- 28/ Hamilton, Trevor and Associates, Progress Report on A Review of the Health Insurance Industry and Public Health Services in Jamaica (November 29, 1988).
- 29/ Blue Cross of Jamaica has instituted physician monitoring programs through panels similar to Professional Review Organizations in the United States.
- 30/ Sweezy, Curtis; Joel Greenspan; and, Larry Forgy. Review of the Jamaican Health Sector and An Assessment of Opportunities for External Donor Support Technologies for Primary Health Care Project, October, 1987.
- 31/ A 1981 study showed 40% of physician visits were to private doctors while

only 12.7% of the population had insurance (Ross/PEU Health Services Evaluation; Sweezy, Curtis; Joel Greenspan; and, Larry Forgy. Review of the Jamaican Health Sector and An Assessment of Opportunities for External Donor Support. Technologies for Primary Health Care Project; October, 1987).

ANNEX E. INSTITUTIONAL AND ADMINISTRATIVE ANALYSIS

The successful implementation of the projects will require a suitable administrative and institutional framework at the Ministry of Health, the hospitals, other public sector institutions and among key private sector players. This section describes the structural constraints within the Jamaican civil service and the impact these have on the efficient operation of the MOH. A review is also included of some reform measures that are being undertaken by the GOJ and management innovations being implemented by the MOH, as well as existing capability to execute projects.

I. MINISTRY OF HEALTH

A. Requirements of a Management System

In order for goods and/or services to be delivered by an organization there must be in place certain basic components. These usually come under the heading of administration or management. The requirements of a management system are:

- A mission statement and strategic plan that gets the program from where it is at the moment to where policy makers want it to be.
- Sufficient financial resources to operate the system at a consensus level of satisfactory performance and a fiscal control system to manage the resources.
- A personnel system that recruits qualified candidates and is empowered to reward superior effort, foster career development, and eliminate less productive members.
- A management information system that accumulates accurate information, in a timely manner, from those who have it and transmits it to those who need it.
- Administrative support systems that keep the program moving.

In addition, there must exist an atmosphere that reinforces the value of the enterprise, acknowledges the contributions of individuals in the overall operation, and reinforces efforts based upon high performance and respect for the integrity of others. A cursory review of the MOH in Jamaica reveals management issues that require addressing. Some of these problems stem from unique circumstances within the MOH; others represent external constraints that the MOH has limited power to change.

B. Fiscal Control

The MOH Finance Division is responsible for budgeting and fiscal control. In the hospital network budgets are set at the regional level, with some involvement of the hospital boards. In the PHC network medical officers initiate the budgets for the health centers in their parishes. In the best of circumstances, the health committees for individual centers provide some input in the process. The formal procedure begins with the medical officer

-2-

presenting to MOH/Kingston a consolidated budget for the entire parish. Traditionally, this has been a "line item" budget for such categories as salaries, rent, utilities, and medical supplies. Individual hospital region and parish budgets are reviewed in Kingston by the appropriate principal medical officer and forwarded to the Finance Division. A budget committee, which includes the Permanent Secretary, Chief Medical Officer, heads of various administrative departments, and the chief of the medical services involved (PHC or hospitals), reviews the budgets. The Finance Division prepares a consolidated budget for the entire Ministry. Recurrent cost budgets are reviewed and negotiated with the MOFP; budgets for capital expenditures are reviewed and approved by the Prime Minister's office. The Minister of Health presents and defends the budget in Parliament.

An initial advance, or "warrant", is forwarded to each hospital region and parish. Subsequent monthly payments are contingent upon receiving a reconciliation of the previous payment. The rationale for this monthly release and reconciliation procedure is that the scarcity of funds precludes a more phased system. The lack of flexibility on the part of MOH financial managers is also a function of the tight management control retained by the MOFP.

Under British colonial rule medical service was something that was provided, with little thought given to the cost of care, efficiencies in service delivery, savings in curative care resulting from effective PHC, or comparative costs of competing services (immunization vs. safe water). In the past few years, however, Jamaica has learned that public services do have a cost and that no system can provide all things to all people. This has precipitated some sound, and politically courageous, decisions on the allocation of scarce resources to the health sector.

For example, in response to a pilot study demonstrating that different mixes of clinic personnel could more efficiently handle the patient load (Zachariah et al., 1987), a project is planned to see if savings can actually be generated by restaffing clinics based on more efficient patterns of utilization. However, since the MOFP retains such tight control over the allocation of finances and the MPS has authority over personnel positions and classifications, the MOH must fight for the authority to realign staff and budgets to maximize service per cost. The Administrative Reform Program (ARP), a government-wide program designed to address constraints on the operation of the civil service, could clearly be an ally in helping the MOH gain this authority.

C. Personnel System

Recruiting and Retaining Staff - Serious problems for the MOH are the recruiting and retaining of management staff and medical and technical specialists. Although this problem is not unique to the MOH, it clearly affects the fulfillment of the Ministry of Health's mandate.

The repeated criticisms of the operation of the MOH, particularly the hospital network, can be traced in large part to staff vacancies. At any point in 1987, from one-quarter to one-third of the required medical positions were unfilled. The problem of unfilled vacancies is directly linked to the issue of overcentralization in the GOJ. This manifests itself at the level of both the line ministry - MOH - and the core ministries, particularly the MOFP,

the MPS, and the independent Office of the Services Commission (OSC) of the Personnel Services Commission. For example, when a Type I health center in a rural area requires a nurse, the request must be approved by the Director of Nursing at MOH headquarters. The Director of Nursing and the Personnel Department identify and interview suitable candidates. However, the MPS is the only ministry currently authorized to approve a position, and the OSC is the only body authorized to hire. Moreover, a MOFP must agree to fund the position even if the slot has been approved by the MPS. Therefore, the MOH staff must (a) receive approval from the MPS for the position, (b) receive authorization from the MOFP to fund the position, and (c) receive approval from the OSC to hire the individual. The process is time consuming and deprives the MOH of the authority to make personnel management decisions.

A similar circumlocution is required when the MOH wants to dismiss a person for cause. The MOH must request an "interdiction" from the OSC on an employee judged to be derelict. The OSC makes a judgement on a course of action, e.g., reprimand, half-pay, or temporary suspension. The OSC then hears and decides every case in the government, a process that can take over a year. The practical effect, according to informal reports by MOH staff, is that many supervisors simply do not take action against non-performing employees because it is not worth the effort. This undermines supervisory responsibility and promotes low productivity and low morale.

The important point to note, however, is that this is not a MOH problem; it is a GOJ problem. The MOH simply illustrates the problem that accrue from overcentralization of management and personnel functions.

Salary Levels - Perhaps the single greatest obstacle to recruiting and retaining high caliber staff is the low salary levels of the Jamaican civil service. A study in 1983 by Technical and Economic Development Associates documented that all civil service salaries are low, but that the remuneration of professional managers is proportionately lower than for technical staff (TEDA, 1983). A target of the ARP is therefore to raise the salaries of civil servants. In the past two years:

- Executive management staff received a one-time increase of over 20%.
- The senior management group and the top grades in the medical fields received a one-time increase of over 10%.
- Executive management and senior management staff received another 7% increase on 1 October 1987, retroactive to 1 July.
- Administrators, financial managers, and natural and applied science groups received an increase of 8-12 1/2% on 1 October 1987, retroactive to 1 July.
- Clerical and support staff received a 13 1/2% increase, also retroactive to 1 July.

Another component of the ARP is the process of "reclassification", or redrawing the competency levels and salary grades for civil service positions. This is an opportunity for the MOH to aggressively pursue the upgrading of managerial positions and to ensure that technical medical specialists are categorized at a level congruent with training and skill levels.

151

Personnel coverage - With shortages at virtually every facility in the MOH system there is little or no room for "backup". Leave days, departmental leave, sick leave, and bank holidays total 65 days a year (13 weeks) for government employees. The result is that civil service workers have 3 months of leave per year. This means a significant number of vacant posts at every point during the year.

A recent article in the West Indies Medical Journal indicates that the greatest percentage of "unproductive" time in observed clinics is due to absenteeism (Desai and McCaw, 1987). Medical officers total "unproductive" time was measured at 35%; for dentists the total was 69%. The Authors explain that a significant proportion of this "absent" time may be due to circumstances beyond the control of the medical staff, e.g., non-functioning equipment. That is only an index, however, of another breakdown in the management system of the MOH - a breakdown that is correctable within the present authority of the Ministry.

One possibility for addressing this situation is for the MOH to press for the authority to pay staff more if they work more. The funds could perhaps be shifted from unfilled posts to cover these additional costs. The individual employee would receive more money, posts would be covered, and presumably service would increase. A corollary would be paying a premium to staff members who have excellent performance records. Again, the ARP should be sought out as an ally in obtaining authorization for such changes.

D. Administrative Support Systems

A serious problem for the MOH is the weak performance of its management support systems: vehicle maintenance, equipment repair, and drug logistics. Inventory controls and performance monitoring do not appear to be in place. Long lead times required by the MOH procurement process make it difficult to accurately anticipate future commodity needs. This problem is compounded by insufficient funds to purchase equipment and supplies, leading to a scarcity of spare parts, frequent breakdowns due to lack of preventive maintenance, and depletion of basic health center supplies. Inadequate transportation is the focus of the most attention during discussions with field staff. Vehicles are not readily available when health center staff need to make home visits. A further frustration is the lack of coordination between the PHC network and the hospital system; there is no reciprocal access to vehicles, even with sufficient justification.

E. MOH Management Innovations

The MOH is currently in the process of undergoing some management changes that have the potential to significantly streamline operations and focus the Ministry on its role and objectives. These changes involve broad policy alternatives as well as day-to-day operational procedures. They include: rationalization, integration/decentralization, and performance budgeting.

Rationalization - "Rationalization" is the term that has been applied to the reappraisal of hospital utilization, particularly of small rural hospitals that are relatively costly to operate but that have low utilization rates. The result of this process has been the managerially efficient, but politically difficult decision to downgrade five small secondary care hospitals into "polyclinics". These will become Type III health care centers with the added feature of lying-in facilities for normal deliveries. Significant savings in recurrent costs and staff have already been demonstrated.

To balance the services lost from downgrading five hospitals, selected other hospitals will have beds added without increasing the basic range of services now given. Polyclinics will refer patients who require hospitalization to these expanded facilities, designated "receiving hospitals".

A third component is the upgrading of some highly-utilized hospitals. Specialty services to be added include radiology, physiotherapy, ophthalmology, and laboratory support.

Integration/decentralization - The MOH is very aware of the fact that operational decision making is concentrated in Kingston. In addition, it is recognized that what has emerged as a two-part system - PHC and secondary care hospitals - has a number of problems. Management functions and personnel are duplicated in the two independently operated systems. Coordination is also inhibited, and referrals from health centers to hospitals are not smooth. Frequently, patients go to hospitals for routine primary health care that the system is designed to provide in health centers. The process is further confused by the fact that the jurisdictions for PHC do not coincide with the ten hospital regions.

The MOH has started to address these problems through a two-part change in management aimed at: (1) merging the parallel PHO and the hospital systems - integration - and (2) delegating more authority, and responsibility, to managers at the area level - decentralization. For example, in the PHC system groups of parishes are being merged as "health areas" for the delivery of PHO services. One pilot area has been created and another is being formed. There have been discussions that a PHC/hospital health area could eventually be managed under the direction of a single area health director.

Performance Budgeting - An important tool in the process of decentralization and integration will be performance budgeting. The area health directors, who are closest to the action, will be expected to monitor the achievement of present goals, within budgetary limits, for their respective areas. They will therefore gain both the authority and the responsibility to efficiently implement the MOH program.

Ultimately, the MOH would like the authority to make management decisions on the type of service mix and personnel required to implement its program in the most efficient manner. Information from the PRICOR operations study would be utilized for such decision making (PRICOR, 1987). At the most, however, the Ministry does not have the authority from the MOFP, the MPS, or the OSC to operate the program in such a manner.

F. Strategic Planning

Over the past five years the policy initiatives of the MOH have, in many cases, been forced upon the staff by fiscal constraints. Nevertheless, the directions they are taking are consistent with the appropriate role of a public health department. Still, because many of the positive steps have been reactions to problems of the moment there has not been an opportunity to put together a strategic plan that permits the MOH to assess where it wants to be in five years, where it is now, and how it will get from its present position to the desired position.

The present policy statements of the MOH are broad descriptions of the intent

187x

of the government to ensure a basic level of health care for all Jamaican citizens in a respectful environment, without regard to their ability to pay. Traditionally, one year's program is an extension of the previous year's inputs. This is routinely a "planning" style with line-item budgeting. Performance budgeting has introduced the opportunity for the MOH to turn this process around. Instead of looking back and reacting to events, the Ministry is in a position to apply forward thinking and planning directed toward explicit goals.

An enhancement to the development of a strategic plan is the crafting of a mission statement that combines the broad objectives of Ministry policy with operational goals. Drafting a mission statement can have the residual benefit of compelling the MOH to review and assess the desired role of a public health department in review and assess the desired role of a public health department in the 1980s and 1990s. Some of the recent policy decisions - rationalization, decentralization, performance budgeting - have initiated this process, but seemingly in a piecemeal fashion. The formal exercise of drafting a mission statement and defining the role of the MOH as part of a five-year strategic plan could integrate these various initiatives into a coherent plan that can then receive policy approval, be articulated to all members of the system (including external donors), and be initiated.

In order for a strategic plan to work there must be a locus for operational and strategic data to be gathered in a timely manner, analyzed, and reported to decision-makers. As part of the forward planning of the MOH it is already envisioned that the health information, planning and evaluation, and epidemiology units will be combined. This combined unit is an obvious center for monitoring the implementation of a strategic plan. Shortfalls, such as in logistical support, maintenance, and purchasing, will become immediately apparent and corrective actions can be taken. At the end of each fiscal cycle performance budgeting will permit the measurement of outputs and the costs for each program component, which then will become the basis for modifying and implementing the next year of the plan.

G. Execution and Monitoring of Projects at the MOH

In addition to having national responsibility for developing and delivering primary, secondary and tertiary health care services, it also operates with an institutional framework to plan, execute and monitor project performance. However, the severe shortage of staff in the Project Planning and project execution units have been a major constraint to the successful implementation of projects.

- The project planning unit has no unit head. Besides, it has only one technical person who is engaged in a junior position. The lack of staff restricts its ability to carefully plan the logistics for project implementation or to monitor on a timely basis. Consequently, numerous projects experience delayed start-ups.
- The project implementation unit is also ineffective due to inadequate staffing. Consequently, much of the responsibility has to be undertaken by the Finance Division.

Since both the project planning and project implementation units have been so ineffective, project execution arrangements have to be established on

individual basis. For example, the Health Management Improvement Project (HMIP) which is a major task being executed by the MOH, is being managed by a special project team whose terms of employment will be terminated on completion of the project. The HMIP team comprises:

- A Manager, who is a medical doctor
- A Financial analyst
- A construction adviser
- A procurement officer
- A director for the alternative financing component
- A research officer
- Several administrative support persons.

The HMIP will terminate in March 1990, consequently the MOH could retain some of these personnel to strengthen its project implementation and project planning and evaluation units.

In addition to the technical staffing arrangements, the MOH executes its project with guidance and monitoring from two project review committees. They are: the advisory/management oriented committee (comprising the Permanent Secretary, the Director of Finance, the Principal Medical Officer for Secondary Health Care, the Project Manager, a representative from the Planning Institute of Jamaica, a representative from the Project Administration and Management Co., and the Project Specialist. This committee meets on a monthly basis. The second committee comprises the same members as the advisory/management oriented committee, but is chaired by the Minister of Health.

II. THE HOSPITALS

The hospitals are in a unique position to execute projects with adequate guidance from two sources: The hospital Management Board and the Ministry of Health. The Hospital Board functions mostly in an advisory capacity. It comprises technical/professional persons; namely the Hospital Administrator and the Medical Officer for the Parish and Community leaders. The hospitals also have day-to-day working relationships with the MOH through the Principal Medical Officer, responsible for Secondary/tertiary health services.

III. OTHER PUBLIC SECTOR INSTITUTIONS

Jamaica has a significant endowment of other public sector institutions which can support the proposed Project in the areas of human resource development, investment promotions, social insurance development, drug procurement policies, sector policy guidelines and finance. They are as follows:

- The University of the West Indies at Mona, Jamaica. It trains personnel in medicine, paramedical skills and management.
- The Jamaica Promotion Ltd. (JAMPRO), which has an excellent track record of developing strategies to improve the investment climate for a wide range of products and services should be able to make very important contributions to the execution of the health industry investment climate component of the project.

- Jamaica's National Insurance agency which is over two decades old is the oldest social insurance related institution in the English speaking Caribbean. It has a solid organizational framework to support social insurance in the Jamaican Health sector.
- The Planning Institute of Jamaica and the Ministry of Finance also have solid organizational structure to support sectoral and fiscal policy initiatives respectfully in the health services sector.

IV. PRIVATE-SECTOR PLAYERS

The Private Sector plays a significant role in production, health services, commerce, health insurance and other financial services in Jamaica. The private sector Technical Assistance Support component of the Project will be implemented by the Private Sector Organization of Jamaica. Other potential collaborating institutions include: The Life Insurance Companies Association, the Medical Association of Jamaica, the Private Hospital Association and the Jamaica Employers Federation.

Table 1 which follows provides a listing of the prime and collaborative organizations recommended for the private sector component of the project.

TABLE 1

1.A. POLICY FRAMEWORK - USER FEE AND INDIGENT CARE

MINISTRY OF HEALTH

It has excellent knowledge of cost of services
It has already initiated the establishment of the required data base
It has the organizational capacity to undertake this risk

MINISTRY OF SOCIAL SECURITY

It could be integrated into the other welfare schemes being executed by this ministry, e.g., the food stamp and the pension schemes

1.A. POLICY FRAMEWORK - SOCIAL INSURANCE AND APPLICATION OF LSMS

MINISTRY OF HEALTH

They are most familiar with the issues
They already have relevant base data
They have the organizational framework to perform the task successfully

MINISTRY OF FINANCE

They will assist with addressing the fiscal implications

MINISTRY OF SOCIAL SECURITY

They have the most appropriate experience in executing social welfare schemes, e.g. the food stamp scheme, the pension scheme, and child welfare scheme.

1.A. POLICY FRAMEWORK - DRUG COST CONTAINMENT

MINISTRY OF HEALTH

They are major users
They are most familiar with the issues
They have the technical expertise
They are most familiar with the policy implications and how to address them

JAMAICA COMMODITY TRADING COMPANY

They are a major importer
They have the required organizational arrangements to undertake the task

THE CHAMBER OF COMMERCE

They are most familiar with the market and distribution issues
Their members include many private pharmacies

1.B. MORE EFFICIENT COST RECOVERY

MINISTRY OF HEALTH

They have the technical expertise
for spearheading
quality/productivity analysis

THE RESPECTIVE HOSPITALS

They will be the beneficiaries
They are engaged in the operations

1.C. SOCIAL MARKETING

LICA

LICA is the umbrella organization
for the insurance companies

MINISTRY OF HEALTH

It is a main provider of service

PRIVATE SECTOR ORGANIZATION OF JAMAICA

It has successfully coordinated
health related promotional
programs
It has adequate organizational
framework

MEDICAL ASSOCIATES OF JAMAICA

Patients are very receptive to
doctors - the Association could
influence the behavior of their
colleagues who are usually
reluctant to adopt cost
containment practices in medicine

BLUE CROSS

It is perceived to be the ideal
health insurance company
It also has the largest share of
the market and is therefore well
positioned to make the best impact

PRIVATE HOSPITAL ASSOCIATION

They are a key provider for paid
health care services

2.A. HEADQUARTERS STRENGTHENING

2.B. ALTERNATIVE FINANCING AND MANAGEMENT

NATIONAL INVESTMENT BANK OF JAMAICA

It has the mandate to undertake
alternative financing projects
It has the track record in
divesting government's services
It has experience in obtaining
financing

THE PROPOSED NATIONAL HOSPITAL TRUST
UNDER THE SUPERVISION OF THE
MINISTRY OF HEALTH

It will have the necessary
institutional and legal framework
It will have easier access to
technical support from the
Ministry of Health
It is already proposed by the GOJ

2.C. PRIMARY CARE

PRIME/COORDINATING AGENCY
KEY ADVANTAGES

COLLABORATING AGENCIES
KEY ADVANTAGES

2.D. SECONDARY CARE

U.W.I. MONA

It has the largest multidisciplinary training capability in Jamaica, comprising Management, Health Management, Medicine, and Paramedicine
It has a track record of performing similar tasks
It has the most appropriate institutional framework.
It enjoys the highest rating accreditation in Jamaica

THE MINISTRY OF HEALTH

They are familiar with training needs
The Ministry of Health will be the main beneficiary

3.A. PRIVATE SECTOR

PSOJ

Appropriate organizational framework
Solid track record in private sector promotion
Adequately staffed with qualified personnel
Standing Health Committee will be given adequate consideration

THE MINISTRY OF FINANCE

The fiscal implications will be adequately assessed

MINISTRY OF INDUSTRY

The sector policy implications will be adequately addressed

PLANNING INSTITUTE OF JAMAICA

The micro economic implications will be adequately addressed

PRIVATE HOSPITAL ASSOCIATION

They are most familiar with the issues and the needs of their members

They have a good working relationship among themselves

JAMPRO

Government's designated agency for investment promotion

**PRIME/COORDINATING AGENCY
KEY ADVANTAGES**

**COLLABORATING AGENCIES
KEY ADVANTAGES**

**OFFICE OF THE SUPERINTENDENT OF
INSURANCE**

They have the mandate to supervise
the industry on behalf of
Government

THE JAMAICAN EMPLOYERS FEDERATION

They are well positioned to
promote employers support

THE MINISTRY OF LABOR

The labor standards requirements
will be adequately promoted

THE TRADE UNION CONGRESS

They are well positioned to
promote as a work condition

LICA

Their members are already in
insurance
They have the institutional
mandate to promote the industry

Private Sector Organization of Jamaica

The implementing organization for the private sector component is the Private Sector Organization of Jamaica.

The PSOJ is a voluntary, national organization of private sector associations, companies and individuals, who are concerned with developing a strong and vibrant private sector.

It was formed in 1976 to:

- promote the principles of private enterprise and the market system as the most effective model of economic growth for our country
- advocate equality of opportunity, freedom and reward for personal initiative
- foster unity and co-operation within the private sector
- lobby government for policies and programs favorable to the private sector
- channel private sector resources to help alleviate the economic and social problems of the country.

The Organization consists of a Council which is elected by the general membership to serve a two-year period. The Council is the governing body of the PSOJ and sets the Organization's policy. The Council elects each year from amongst its members an Executive Committee consisting of the President, three Vice-Presidents, an Honorary Secretary, an Honorary Treasurer, and seven members. The Executive Committee, is also an ex-officio member of that Committee. This Executive meets on a monthly basis and sees to the overall running of the Organization.

In carrying out its aims and objectives, the PSOJ engages in a wide range of social and economic activities through its three main divisions, Economic Research, Human Resource and Enterprise Development, and Communications and Membership. Some of the Organization's activities include publications of in-depth economic analyses and forecasts, helping community groups to start businesses, promoting entrepreneurial education in the schools and lobbying government on behalf of business interests.

In 1981, the PSOJ and the Jamaica Chamber of Commerce created the Jamaica-America Medical Assistance Committee (JAMAC) for the purpose of securing and coordinating overseas donations for the island's health services. JAMAC also coordinates visits to Jamaica by medical personnel from abroad who give their services free of cost.

1954

ANNEX E
INSTITUTIONAL AND ADMINISTRATIVE ANALYSIS

-14-

In its seven years of operations, JAMAC has received donations for the public hospitals to the value of over J\$50m. The local private sector has contributed approximately J\$1/2m to fund the operations of JAMAC and airline and shipping companies have donated freight space to move the donations from the USA and Canada to Jamaica.

PSOJ has received previous assistance from USAID for various activities including recent PSOJ Development Grant. The purpose of this grant was to provide support in developing institutional capability to analyze the economy, organize the private productive sector, and increase their capability to carry on effective dialogue with the GOJ.

This Project will fall within the Human Resource Development Division of PSOJ which will be responsible for the day to day administration of the Private Sector Component. Policy guidance and monitoring oversight will be the responsibility of the Health Committee. This Committee consists of representatives of the private sector health groups and health professionals. The HSIP Project Manager will be installed as a member to ensure coordination between the two components.

ANNEX F. SOCIAL SOUNDNESS ANALYSIS

I. General

The project is quite timely. It comes at a time when both major political parties are promoting the health services sector as a key component in the "Social Wellbeing Program" which will be the main focus in the medium term Jamaican socio-economic development program. The services generally deteriorated under the 1983/88 economic structural adjustment program which shifted resources from the social to the productive sectors especially to export oriented ones. This revised high priority positioning of the health services in the national development program, will enhance the success of this proposed project.

Sociocultural Feasibility - The findings of this analysis are that the Project is compatible with the sociocultural environment and that the impact and benefits of the Project are consistent with overall development objectives in reaching poorer and disadvantaged populations such as women, the elderly and the unemployed. The proposed implementation framework for the project is appropriate and designed to broaden and deepen the public - private collaborative efforts in the economy. It is a major initiative to facilitate a greater role for the private sector in health care services, as it now accounts for less than 15% of the services provided. The Project's support of cost recovery of expenditure among socio-economic stratas which can afford to pay will also enhance the GOJ's ability to provide improved services to the public.

The Project execution will demand the participation of a wide range of public and private sector institutions and professional personnel. The Project aims to improve the quality of health services for all Jamaicans which is an important national priority. This will be supported through improved financial viability of the MOH and its ability to deliver quality health care.

Beneficiaries - The Project will address the management and financial constraints of the public sector health care system with the ultimate goal of improving the quality of care in the public sector. The GOJ is committed to providing or financing medical care for those who cannot afford to pay. The Health Expenditure Survey (McFarlane and McFarlane) found that female respondents are more likely than male respondents to have utilized all types of health facilities, and females are more likely than males to identify public health centers as their most frequently utilized health facility.

It is estimated that there is near universal access to health care in Jamaica. The 1988 Living Standards Measurement Survey (LSMS) found that 55% of those reporting illness or injury received medical care, with little variation between the poorest and wealthiest quintiles, and no gender variation. However, the survey did find that women report more illness than men: 17% of the females reported illness or injury in the previous four weeks versus 14% of the males surveyed. In terms of income level, the survey found that whereas 18% of those surveyed utilized health centers for medical consultations, 40% of those in the lowest quintile did so. Of some concern is

the finding that 32% of health care contacts were with public health clinics in 1983 (Ross Institute Report), which has declined to the recent finding of 18%. Those reporting the hospital as their source of medical care has remained stable at 25% between the two surveys. For those selecting non-hospital care, there is an emerging pattern of declining use of health centers with increased income, and a corresponding increase in use of private physicians. What is surprising is that the poorest groups also utilize private physicians to a great extent; per the LSMS, whereas 40% report health centers as their point of contact, 38% report private physicians as their point of contact. Thus there is a willingness to pay for medical care, perceived to be of high quality, even among the lower income groups.

This finding will support the Project's objective of increased cost recovery in the public sector since there is a demonstrated willingness to pay for health care. Simultaneously, the major weakness of the current system which is that those who use the public system and can afford to pay for that care are not doing so because proper fee collection systems are not yet in place will likewise be addressed.

A recently completed Health Expenditure Survey (McFarlane and McFarlane) found that children under the age of 14, women, the unemployed, the lesser educated, and the elderly, are the most frequent users of public health clinics and health centers. The survey found that women disproportionately use public health clinics: 63% of females less than 14 years of age use health centers versus 56% of males. In the 14-59 year old age groups, 46% of the females versus 29% of the males use public health clinics. In the 60 year old and above age groups, 52% of the females versus 34% of the males use public sector clinics. Users of public hospitals are 55% female and 46% male. Among unemployed persons over the age of 14 years, 33% of unemployed females use public clinics compared to 19% of unemployed males. Compared to those who utilize private facilities, those who utilize public clinics come from households with a large number of children and unemployed as members. The technical analysis outlines deficiencies in the quality of care given in public facilities due to management and financial difficulties. By the end of the Project, all 13 parishes will have implemented the PRICOR scheme which redeploys staff to the health centers within a region to ensure that they are properly staffed and services offered. This will result in better quality of care and savings of time and money of patients since they can obtain services at a lower cost (financial and opportunity).

In sum, it can be included that improvements in the managing and financing of the public health care services, which result in better quality health care will directly benefit the poor, unemployed, females and elderly. Individual private health care professionals who are reluctant to practice economic services are likely to be the only disadvantaged group with the execution of the components relating to (i) social marketing of cost containment drug utilization and competitive insurance coverage and (ii) improved public sector services.

The Table which follows illustrates how selected project components will benefit the various groups.

ANNEX F
SOCIAL SOUNDNESS ANALYSIS

-3-

Spread of Benefits - Health facility staff will benefit from improvements made in efficiency, management and financial viability of public sector facilities. If more fees are collected and retained in the collecting facility, the means will be available for staff incentives. In Jamaica, nursing staff, approximately 2,425 persons of which 95% are female are working in unsuitable working conditions leading to low morale, outward movement from Government service, and acute shortages. Improved working conditions in both public and private sectors will likewise benefit medical doctors, estimated at 1,000 persons, 35-40% of which are females. Since public sector health staff account for 25 percent of all public service employees, any positive impact on their terms and conditions of employment will make a significant contribution.

The Project will target private as well as public health care facilities for assistance. This should not be viewed as assistance for generating profits as most private sector health concerns are experiencing major financial difficulties--be it hospitals, laboratories or the health insurance industry. However, the degree to which the private sector health entities can become viable and functional, they will automatically attract the clientele that can afford to pay or which has third party coverage for their care. As stated previously, this will allow the public sector to concentrate its limited resources on providing or financing care for those persons who cannot afford to pay.

199X

KEY PROJECT COMPONENTS AND THEIR BENEFICIARIES

<u>PROJECT COMPONENTS</u>	<u>BENEFICIARIES</u>	<u>KEY AREAS OF BENEFIT</u>	<u>LIKELY MAGNITUDE</u>
1. Technical Support for Private Sector	Private Hospitals	- Improved efficiency - More effective cost containment practices.	About 4 hospitals
2. Drugs cost containment	Insurance companies Patients - rich - poor	- Improved financial viability - Improved affordability of drugs Improved affordability of health insurance	Entire industry Over 1 million persons Over 100,000 persons
3. Health Industry Analysis	Private investor MOH/MOF Patients	- Improved profitability and ease of doing - Reduced expenditure - Improved standards of services derived from increased competition among providers.	Unknown Unknown Unknown
4. Commercial Insurance Expansion	Insurance Companies Health care Personnel MOH patients	- Improved financial viability - Improved compensation from increased financial inflows - Improved cost recovery - Improved health care services from increased resource support.	Unknown Unknown Over 20 million annually.
5. Social Marketing	Insurance Companies Patients MOH	- Profitability - Improved affordability - Reduced spending	Unknown Unknown Unknown
6. Hospital Staff Training	Personnel Patients MOH/Hospitals	- Career advancement - Improved quality of service - Improved efficiency and increase staff situations.	Unknown Unknown Unknown

200

ANNEX F
SOCIAL SOUNDNESS ANALYSIS

-5-

7. User Fee Reform and Indigent Financing	MOH	- Increased cost recovery	Scope of collecting up to \$43 million annually.
	Patients - rich - poor	- Improved services from greater financial support	Unknown
8. Health Care Cost and Quality Assessment	MOH	- Increase cost-effectiveness	Unknown
	Patients	- Improved services	Unknown

2017

ANNEX G. ECONOMIC AND FINANCIAL ANALYSIS

I. Background: Economic and Financial Context

Jamaica's economy has deteriorated over the last decade or more, although economic circumstances have begun to improve since about 1986. The measures of economic performance over the period indicate that:

- between 1965 and 1984 GNP grew at -0.4 percent;
- GDP dropped by 25 percent from 1974 to 1987;
- inflation increased at an annual average rate of 16.6 percent between 1973 and 1984;
- the public and private debt service increased from 1.1 percent of GDP to 13.8 between 1970 and 1984; and
- unemployment hovered about 25 percent per year during the 1980 to 1985 period.

The macroeconomic problems have constrained government expenditures due to both limited tax revenues and to agreements with the International Monetary Fund on expenditure levels and expansion of public debt. Total government expenditure in 1986-87 is projected to be 42 percent of the GDP, but this reflects the high debt service of the government. Net of amortization and interest on both foreign and domestic debt, the government budget is only 24 percent of GDP. Total recurrent expenditure is projected at 28 percent of GDP, 11 percent of which covers interest payments.

The trend in government expenditure, both capital and recurrent, is only increasing modestly, with a considerable proportion of the increase due to reusing amortization and interest payments. The latter claimed about 26 percent of total expenditure in 1984/85 and about 42 percent in 1986/87. Moreover, the total deficit has fluctuated during the period but has not been significantly reduced. Net of amortization, government expenditures have fallen and the budget deficit halved between 1983/84 and 1986/87. As of 1986/87 the deficit stood at J\$429 million (Economic and Social Survey, 1988).

Despite the budget pressures, the Ministry of Health (MOH) has received increasing nominal dollar support from the government, particularly for operating costs. Real spending by the MOH, however, has declined significantly during the decade. Real per capita spending has declined as well, with public sector spending falling by about one-third in real terms between 1982/83 and 1985/86.

Between 1984/85 and 1986/87, the MOH recurrent budget as a percentage of the government budget rose from 7.8 to 9.2 percent, reflecting a relative increase in the government's commitment to health care. The MOH has publicly stated that the 9.2 percent is expected to remain stable for the near term (Project

ANNEX G
ECONOMIC AND FINANCIAL ANALYSIS

-2-

Hope, 1985), although there is the possibility that the new government will set a different agenda. The proportion of government expenditures allocated to health has actually declined in total, however, due to the limited capital investment in the sector. The MOH receives much less of the government capital budget, and the neglect of major health infrastructure reflects the negligible capital budget allocations.

Despite the aggregate figures on inflation and expenditure, the effect of macroeconomic trends on the real value of MOH expenditures has been mitigated by the fact that 50 to 60 percent of the budget is allocated to personal emoluments. Public sector wages have remained relatively stagnant over the past five to six years. The attrition of public workers, particularly among the most highly skilled (eg., specialists, physicians and nurses) is linked to low pay and to the deteriorating physical environment, which severely affected the productivity of public health workers (Swezy. et al., 1987; PRICOR, 1986). The loss of morale and leadership in the MOH and its facilities may parallel the value losses associated with inflation and may equal the loss in terms of productivity and lost labor. The cost of other medical inputs (other than wages) has risen more rapidly than overall prices (Taylor, 1988), which amplifies the impact of inflation and devaluation on the real value of the MOH supplies budget. In sum, inflation and fixed wages have reduced the value and productivity of the public health care system.

The allocation of central government funds in health is a particularly important issue because it is the complementary inputs that have been unaffordable and have seriously affected the quality, efficiency and effectiveness of the health care system. Indeed, lack of supplies and drugs has in some cases made labor an ineffective input into health care delivery. As mentioned, personal emoluments claim the single largest portion of the budget. Allocations to supplies, which include drugs, medical supplies, nonmedical supplies and maintenance, remained largely stagnant over the three years, 1983/84 through 1985/86.

In 1985/86 supplies were 15 percent of the budget, down from 18.6 percent three years earlier. During that same period, the Jamaican dollar fell by 105 percent thereby raising the cost of all imported inputs both medical and nonmedical. Between 1983/84 and 1985/86, drug expenditures rose sharply in most hospitals, which suggests a rise in allocations for drugs forced at least in part by the devaluation. Since the budget figure for all supplies in the system remained close to constant during that period, the rising level of pharmaceutical expenditures required a contraction in resources available for other supplies and maintenance. In short, supply expenditures dropped not only in real but also in nominal terms, seriously affecting public hospital services (see Lewis, 1988 for an indepth disussion of this issue).

Another phenomena of public health finances is the sharp rise in appropriations in aid (revenues raised by the MOH system) over the past few years. Collections went from J\$19,000 million in 1984/85 to J\$28,000 million in 1985/86, an almost 50 percent increase. Nineteen-eighty-four was the first year under the new hospital user fee schedule. In 1986 facilities were allowed to claim the revenue, which may account for the rise in appropriations in aid. The revenue retention reflects a reinterpretation of the definition

203X

of fee earnings, and allowed hospitals to invest in physical plant repairs as well as medical supplies and drugs (Lewis, 1989). These expenditures provided a cushion, though an inadequate one, to allow facilities to continue operation. Since many hospitals' water and security systems were nonfunctional and whole wings unusable because of faulty wiring, the fee revenues allowed the most egregious problems to be addressed.

II. Project Purpose

This project addresses the managerial and economic ills of the current health care system by emphasizing: (1) the raising of revenue and reduction of costs (through increased efficiency) in the public system, with concomitant efforts to reduce subsidies to those who do not need them; (2) improve the management of the public health system both at the central level and at secondary care delivery points; and, (3) efforts to enhance the role of the private sector as a provider of health care through initiatives that directly stimulate expansion of private supplies of care, and by broadening health insurance or health maintenance organization (HMO) coverage to stimulate demand for private health services.

These objectives are to be achieved through an integrated, disparate set of activities which (1) identify the problem (e.g. measure resource costs, studies of health care financing issues, drug management studies); and, (2) address the problem (management training, private sector promotion, drug management improvement, user fee reform and accommodation of the indigent, alternative financing arrangements for public hospitals). Many of these initiatives are experimental in nature and there are plans for intensive evaluation of the costs and benefits of each of these. The following subsection provides an effort at an economic analysis of the project components.

III. Expected Benefits and Costs of Project Components

The costs and benefits of the project are difficult to quantify given the nature of the project components. Because the resources are aimed at assisting policymakers in devising more effective policies and translating these into tools for financial and organizational reform of the health care system, and at promoting greater private sector investment in health care, a set of flexible activities has been designed. While cost benefit analysis is difficult to conduct because the benefits are largely nonquantifiable, cost effectiveness analysis is highly inappropriate since the project components address specific issues and are largely illustrative. A cost-benefit comparison between this policy reform kind of project and, say, construction is not helpful since the expected benefits are too dissimilar. Thus this section discusses the benefits, what they are and when they might occur, and then estimates the costs of each component and the recurrent cost implications of each.

Each separate project component is listed in Table 1 with an accompanying description of the expected benefits. Benefits will occur at two points:

204

both immediately, i.e., as information to policymakers, and as an input to decisionmaking that will, in turn, reap further benefits in the future. In most instances both tiers of benefits are mentioned in sequence. The benefits assumptions, however, are often based on the assumption that policymakers will act appropriately based on expected outcomes of studies and experiments. This, of course, cannot be guaranteed.

The timing of benefits can be seen in Table 2 where the same components are listed with the expected timing of planning, implementation, policy consideration, policy change and benefits indicated for each. As mentioned in the previous paragraph, benefits may only accrue if certain policy changes are made. To the extent possible this is indicated in the table. Moreover, some effort has been made to estimate the sequence of actions leading to the benefits so the tenuous nature of the specific benefits listed in Table 1 are clarified.

As a package, the components cover the weaknesses of the MOH and provide the government with the resources to identify precisely the nature of problems and to consider, undertake and evaluate alternative interventions for addressing the problem. The list is thorough and, if implemented as anticipated, would provide the government with information to assist them in designing and reforming health care delivery and finance.

The cost of the project is summarized in Table 3, again by component. The recurrent cost implications are modest, with the registry of indigents and the loss of tax and tariff revenue posing the most significant costs. The loss of tariff revenue could affect other programs, however. For instance, generic drug importers' currently carry a heavy tariff that is used to finance the National Housing Trust. Eliminating that tariff would affect housing finance objectives of the government and require that alternative sources of funds be identified for that program. Thus, the revenue loss is likely to be the most serious financial cost over time. The magnitude of the impact, however, cannot be assessed with existing data.

The costs are divided among eight different tasks, and the recurrent costs are generally low. The policy reform focus of the project may well have the impact of a net financial gain.

TABLE 1
NATURE OF BENEFITS OF PROJECT COMPONENTS

PROJECT COMPONENTS	NATURE OF BENEFITS
1. <u>PUBLIC SECTOR - FINANCING</u>	
a. <u>Policy Framework</u>	A series of analyses to assist the GOJ in taking policy decisions which facilitate sustainable mechanisms for financing health care in Jamaica. Resultant policy changes could expand demand for private health care services through increase in insurance coverage instead of relying on subsidized public system. Follow through on recommendations relating to Drug Management could result in benefits encompassing: (1) improved and less costly public procurement of drugs; (2) adjusting tariffs on essential drugs to reduce the cost and thereby increase access to privately provided drugs; (3) reduction in the number of over prescriptions in the public and private sectors; and, (4) reductions in the cost of medical inputs due to adjustments in tariffs.
b. <u>User Fee Reform</u>	Administrative systems in place to collect hospital fees and insurance payments which will (1) reduce the underfinancing of publicly provided health care, provide incentives to providers in the public system, and improve quality of care through greater affordability of non-labor inputs; and, (2) reduce management costs and oversubsidization of health care through more accurate registry and definition of indigence.
c. <u>Social Marketing</u>	Consumer knowledge and understanding of privatization, necessity of payment at public facilities, generic drugs, and virtues of insurance coverage.
2. <u>PUBLIC SECTOR - MANAGEMENT</u>	
a. <u>Headquarters Strg.</u>	Restructuring of headquarters resulting in improved planning and anagement capability; more efficient financial, personnel, and supply systems in place due to modern management technologies.
b. <u>Alternative Mgmt.</u>	Decentralized management structures in place for primary and secondary care; integrating FHC and secondary care into same region; strengthening role of hospital boards; and contracting out hospital support services,.

- c. **Primary Health Care** Primary care services rationalized in all parishes through redeployment of staff and improved facility utilization; completed operations research demonstrating cost savings and quality of care improvements.
- c. **Secondary Care** Improved efficiency and effectiveness of secondary care public facilities with systems in place to ensure sustainable changes and lower costs/higher quality services.
- 3. **PRIVATE SECTOR** Improved business climate for private investments in health care service delivery, which will help expand private investment in the sector. Improved operation and more efficient private facilities that are financially solvent and can serve a larger segment of the patient population thereby reducing the role of any subsidy from the government. Benefits will occur once managerial improvements affect quality and efficiency of supply and demand can both be satisfied and increased. Expanded commercial insurance in order to promote demand for private health care services instead of relying on subsidized public system.

* Benefits are contingent on policy change with the GOJ.

207x

TABLE 2
PROJECT COMPONENTS AND TIMING OF BENEFITS

PROJECT COMPONENTS	Timing of Benefits Accrual						
	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7
1. PUBLIC SECTOR - FINANCING							
a. Policy Framework	Study/Policy Consideration	Study/Policy Consideration Implementation	Study/Policy Consideration Benefit/ Implementation				
b. User Fee Reform	Implementation	Benefit/ Implementation	Benefit/ Implementation	Benefit	Benefit	Benefit/ Implementation	Benefit*
c. Social Marketing	Planning	Implementation	Benefit/ Implementation	Benefit/ Implementation	Benefit/ Implementation	Benefit/ Implementation	Benefit/ Implementation
2. PUBLIC SECTOR - MANAGEMENT							
a. Headquarters Str. Planning		Implementation	Benefit/ Implementation	Benefit	Benefit	Benefit	Benefit*
b. Alternative Mgmt.	Planning Analysis	Planning Analysis Implementation	Benefit Analysis Implementation	Benefit Analysis Implementation	Benefit Analysis Implementation	Benefit Analysis Implementation	Benefit* Analysis Implementation
c. Primary Health	Evaluation Implementation	Benefit Implementation	Benefit Implementation				
d. Secondary Care	Training Implementation	Training Training	Benefit Training	Benefit	Benefit	Benefit	Benefit*
3. PRIVATE SECTOR							
a. Investment Study	Study	Recommendation Consideration Policy Change	Policy Change	Benefit	Benefit	Benefit	Benefit*
b. Technical Support Planning		Implementation	Benefit Implementation	Benefit Implementation	Benefit Implementation	Benefit	Benefit

* Benefits are contingent on policy change with the GOJ.

TABLE 3
PROJECT COMPONENT COSTS AND RECURRENT COST ESTIMATES

<u>PROJECT COMPONENTS</u>	<u>ESTIMATED COSTS (US\$000)</u>	<u>RECURRENT COST IMPLICATIONS</u>
1. <u>PUBLIC SECTOR - FINANCING</u>		
a. Policy Framework	415	None.
b. User Fee Reform	259	Continued monitoring of user fee system and support to continue the registry of indigents and financial management of health care for the indigent.
c. Social Marketing	385	None
2. <u>PUBLIC SECTOR - MANAGEMENT</u>		
a. Headquarters Strg.	236	Paying for electricity use and other support for computer maintenance and use.
b. Alternative Mgmt.	638	Regulating contractor(s)
c. Primary Health Care	126	Costs assisted with possible reforms and greater decentralization.
d. Secondary Care	684	Possible follow-on assistance to ensure sustainability of improvements, but not essential.
3. <u>PRIVATE SECTOR</u>		
4. <u>PROJECT IMPL.</u>	998	None
5. <u>AUDIT/EVALUATION</u>		
	229	None

ANNEX H. ENVIRONMENTAL THRESHOLD DECISION

RCU BY: XEROX TELECOPIER 7010 ; 8-15-88 2:49PM ; 202 647 5269 2504621- 8099293752: # 3
08/15/1988 14:50 OFDA Washington, DC USA 202 647 5269 2504621 P.03

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON DC 20523

LAC-IEE-88-32

ENVIRONMENTAL THRESHOLD DECISION

Project Location : Jamaica
Project Title : Health Sector Initiatives
Project Number : 532--152
Funding : \$4,540,000
Life of Project : 5 years
IEE Prepared by : Charles Matthews
USAID/Kingston
Recommended Threshold Decision : Categorical Exclusion
Bureau Threshold Decision : Concur with Recommendation
Comments : None
Copy to : William Joslin, Director
USAID/Kingston
Copy to : Andre DeGeorges, RDO/C
Copy to : Charles Matthews, USAID/Kingston
Copy to : Patricia Buckles, LAC/DR/CAR
Copy to : IEE File

James S. Hester Date JUL 29 1988
James S. Hester
Chief Environmental Officer
Bureau for Latin America
and the Caribbean

210X

ENVIRONMENTAL DETERMINATION

Program: Jamaica
Title: Health Sector Initiatives Project
Number: 532-0152
Funding Source: DA, Health
Proposed Obligation: FY 1989
LOP Funding: \$4,540,000
Proposed LOP: 5 years
Mission Determination: CATEGORICAL EXCLUSION
Prepared By: Charles R. Mathews,
Mission Environmental Officer

Charles R. Mathews

A. Activity Description: The proposed activity will seek to improve the health and nutritional status of the Jamaican people and improve the quality and efficiency of health care delivery services (Goal). The Project will consist of alternative methods of financing/delivering health care services and increasing the efficiency of planning and management of health care services.

Proposed Project activities do not contemplate any construction or other influence on the natural or physical environment.

B. Discussion: Implementation of the proposed project activities will involve technical assistance, training, research, and some commodity procurement which, when weighed against the criteria in Section 216.2 (c) (1) and (2) of AID's Environmental Procedures, are considered to qualify for a Categorical Exclusion for which an Initial Environmental Examination is generally not required.

This statement is submitted for Bureau Environmental officer review in accordance with Section 216.2 (3).

C. Approval

Approved: *TR Tiff*

Disapproved: _____

Date: 7/18/88

Thomas R. Tiff
Acting Mission Director
USAID/Jamaica



ANNEX I
LETTER OF REQUEST FROM THE GOJ

PIOJ

PLANNING INSTITUTE OF JAMAICA

TELEX 3529, PLANJAM JA

FAX # 9264670

P.O. BOX 634,
KINGSTON,
JAMAICA.

ANY REPLY OR SUBSEQUENT REFERENCE
TO THIS COMMUNICATION SHOULD BE
ADDRESSED TO DIRECTOR GENERAL,
PLANNING INSTITUTE OF JAMAICA,
39-41 BARBADOS AVENUE.

July 6, 1989

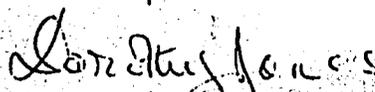
Dear Mr. Joslin,

Health Sector Initiatives Project

This letter constitutes a formal request from the Government of Jamaica to the United States International Development Agency (USAID) for a grant of Five Million United States Dollars (US\$5M) to support execution of the Health Sector Initiatives Project as described in Project Document No. 532-0152.

We look forward to a positive response to this request.

Yours sincerely,


(Mrs.) Dorothy Jones
for Director General

Mr. William Joslin
Director
United States Agency for
International Development (USAID)
6B Oxford Road
Kingston 5



MINISTRY OF HEALTH

ANY REPLY OR SUBSEQUENT REFERENCE
TO THIS COMMUNICATION SHOULD BE
ADDRESSED TO THE PERMANENT
SECRETARY AND THE FOLLOWING
REFERENCE QUOTED:-

No. _____

10 CALEDONIA AVE.,
P.O. BOX 472
KINGSTON, JAMAICA.

29th June, 19 89

Mrs. Rebecca W. Cohn,
Director,
Office of Health/Nutrition/
Population,
6B Oxford Road,
Kingston 5.

Dear Mrs. Cohn,

Re: Ministry of Health Hospital User Fees

I write in reference to your letter of June 5, 1989 in
which you sought assurances that:

1. Fees collected will be made available to
collecting facilities and over time,
approach 100% of the amount collected.
2. The fees will be additive to the regular
Ministry of Health Budget.

You are no doubt, aware that although the automatic refund
is 50%, it is possible for institutions to be reimbursed 100% of the
fees collected, provided this is justified by the institution.

The Ministry of Health undertakes to continue this policy
and plans to review the percentage of fees subject to automatic
reimbursement over time, without prejudice to the need of the Ministry
of Health to ensure improved efficiency in the entire Health System.

Mrs. R. W. Cohn,
Director,
Office of Health/Nutrition/
Population

29th June, 1989

With regard to (b), the fees collected have been and will always be additive to the regular Ministry of Health Budget regardless of how the documentation may appear in the Estimates of Expenditure.

Yours sincerely,



R. A. Ramcharan,
Permanent Secretary