

GOVERNMENT POLICY AND
THE EFFECTIVENESS OF USER CHARGES
IN JAMAICAN HOSPITALS

Jamaica

October 1988

**Resources for
Child Health
Project**

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I. INTRODUCTION

Jamaica has one of the healthiest populations in the developing world. Its infant mortality rate is 13 per 1000, life expectancy is 70 and the total fertility has declined sharply in recent years to 3 percent. The country's health problems are a combination of the heart disease, accidents and neoplasms found in developing countries, and of high maternal mortality (1.1 per 100 live births) and malnutrition that are associated with developing countries (Swezy et al., 1987).

At the same time, Jamaica has been plagued by many of the economic and financial difficulties that are facing other developing countries. High debt, rising inflation, and restricted government budgets have also caused real reductions in the resources allocated to public health, including public health care services. The effects on health care have been sufficiently severe to prompt widespread concern both within the government and within the society at large due in large part to a perceived and actual decline in the quality of services (Ross Institute, 1985).

In response to the crisis in public health care provision, the government has devised a range of means for dealing with the problem. The first of these was a revised user fee policy. A major innovation involved a revamping of federal collection and expenditure requirements to allow facilities to keep some portion of their revenues to both offer incentives to facilities to collect and to improve performance, and to supplement hospital budgets, which have sustained significant real budget cuts since the early 1980s. This radical departure from the British system of remitting all collected revenues to the central government involved Parliamentary approval and therefore broad, and high level support.

This paper analyzes the user fee system and its effects on public hospitals. The nature and magnitude of Jamaica's macroeconomic and financial difficulties and the effects on the public health sector are provided as background to the analysis of the government's experience before and after the revision in user fee policy. As part of the analysis, the trends in hospital budgets, revenues, and expenditure of discretionary revenue are examined in depth, and the issue of equity is addressed.

II. DATA

Data on user fees were collected from Ministry of Health (MOH) files and those of each hospital region. Since the policy directive of late 1985 hospitals have made (quasi) monthly reports of earnings to the central Ministry and most facilities have submitted budgets proposals for spending the revenues. Fee earnings prior to 1985 were obtained from hospital records. Hospitals were contacted either in person or by telephone to obtain the data. A specific, written request was sent to each regional hospital (where all hospital financial data are collected and filed) through Ministry of Health channels; and, finally, follow up telephone calls and visits were made where necessary to ensure a complete inventory. Gaps in Ministry of Health reports after 1985 were supplemented by hospital records where possible.

Nine facilities were visited and the director and administrator interviewed regarding the accuracy of the MOH data, the operation of the user fee system, the significance of the revenue to hospital operation, and the impact of the new revenue on hospital operation. All public hospitals are included in the study with the exception of Bellevue Psychiatric Hospital.

III. STRUCTURE OF PUBLIC HEALTH CARE

Jamaica's health care services are provided free or at nominal charge to all citizens, and no patient is denied care whether or not they can afford the assessed charges.

Jamaica's public health care system includes 24 hospitals, 447 primary health care clinics, environmental health, and centralized services in the Ministry of Health to serve these networks (National Laboratory, blood bank, Island Medical Stores, and National Maintenance Unit). Hospitals are divided into categories and regions. Categories are Type C (basic inpatient and outpatient care in medicine and maternal child health), Type B (includes specialist services in some areas), Type A (full range of secondary and tertiary care), and specialty and chronic care facilities. The full range of facilities and the level and kinds of services offered are summarized in Table 1.

Regional hospital divisions allow the largest hospital to carry the financial management responsibility for the facilities in their catchment area. Budgets, user fee revenue management, access to centralized services and other functions are accomplished through the regional hospital, which can be Type A, B or C.

Table 2 provides a list of the 23 public hospitals (excluding the quasi-public University of the West Indies Hospital) with information on the level (Type), size, volume of inpatient, outpatient and casualty, and operating efficiency measures of occupancy and average length of stay (ALOS). Volume of patients varies widely with no apparent pattern among bed size, inpatients and outpatients. Occupancy rates are generally quite high, as would be expected in a largely free-care system. Spanish Town Hospital's 102 percent reflects the

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Table 1

Distribution, Number, Personnel, Catchment Area, and Service Provided at All Levels of the Public Health Care System

Health Center/ Hospital Level	Number	Level of Personnel	Location/ Immediate Catchment Area	Services Provided
Type I	245	Midwife, 2 CHA ^a	4,000-5,000 population	MCH home visits
Type II	93	Public health nurse, public health inspector; RN, MD and dentist visit	10,000-12,000 population	Curative, pre- ventive and promotive
Type III	84 ^b	MD, nurse practitioner & dentist (who also serve Type II centers)	Parish center	Curative and pre- ventive at more sophisticated level
Type IV	b	Combination of Type III center and the parish office	Parish center	Curative and pre- ventive at more sophisticated level
Type V	25	MD, some specialists, nursing care, dentist	Undefined	Specialty out- patient care & PHC
Type C Hospital	11	Basic, district hospital with x-ray & lab. Surgeon for emergency; 2-3 MDs	Parish center	Inpatient and out- patient care in medicine & MCH
Type B Hospitals	4	MD specialists	Urban centers	Inpatient and out- patient, specialist service at least in surgery, inter- nal medicine, OB/GYN & pediatrics
Type A Hospitals	5 ^c	MD specialists	Kingston, Montego Bay	Full range of secondary and tertiary care
Other Hospitals	4 ^d	MD specialists	Kingston	Chronic specialized care

a. CHA = community health workers.

b. Includes Type III and IV together.

c. Includes University of the West Indies Hospital.

d. Maternity, Children's, Psychiatric, and Chest hospitals.

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Table 2
 Characteristics and Utilization of Public Hospitals, 1987-88^a

Type	Number of Beds	Number of Discharges	Casualty	Outpatient Attendance	Occ. Rate	ALOS
<u>Type A</u>						
Kingston Public	514	12,715	73,823	84,655	84	11.9
Cornwall Regional	326	10,745	53,079	51,663	81	8.3
<u>Type B</u>						
St. Ann's Bay	140	7,827	23,306	7,349	95	4.8
Sav-la-mar	194	6,821	20,281	13,082	77	6.6
Mandeville	163	7,629	32,957	24,171	82	5.1
Spanish Town	252	12,721	44,216	23,528	102	6.6
<u>Type C</u>						
Princess Margaret	164	5,862	22,820	5,106	72	4.4
Port Antonio	125	3,724	11,518	6,357	66	6.7
Annotto Bay	122	2,930	8,454	407	57	7.7
Port Maria	94	2,541	8,343	5,696	58	6.7
Falmouth	102	2,555	5,127	2,566	56	8.2
Noel Holmes	55	2,286	5,508	189 ^b	85	6.7
Black River	115	4,675	16,689	n.a. ^c	68	5.6
Percy Junior	122	5,054	11,793	6,127	83	4.7
May Pen	70	3,177	15,909	1,529	78	5.4
Lionel Town	60	1,937	23,583	10,195	66	7.1
Linstead	50	2,427	10,792	1,869	63	4.8
<u>Specialty</u>						
Victoria Jubilee (maternity)	229	15,732	0	51,169	71	3.0
National Chest	116	1,032	1,231	2,921	86	26.0
Bustamente (children's)	215	6,598	48,850	23,758	70	6.7
Bellevue (psychiatric)	1,600	525	0	4,988	n.a.	n.a.
Hope Institute (hospice)	52	188	N/A	N/A	51	48.8
Mona Rehabilitation	111	n.a.	N/A	N/A	n.a.	n.a.

Source: Hospital Statistics Reports, 1982-1988.

n.a. = not available
 N/A = not applicable.

- a. Data are estimates
 b. Outpatient department but no clinic.
 c. Visits included in casualty.

extremely high occupancy rate in maternity where two women to a bed is common. Average lengths of stay are high overall, and generally exceed the 6.3 ALOS in U.S. short stay hospitals (NCHS, 1988). Victoria Jubilee Hospital's 3.0 day for maternity is quite low by international standards since high risk pregnancies are more likely to delivery at that hospital than at other facilities, and these women are more likely to need additional hospital days.

IV. FINANCING PUBLIC HEALTH CARE: THE PROBLEM

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. Negative macroeconomic growth over the past decade, average annual inflation of 16.6 percent and a rapidly climbing debt service prompted the government to curtail spending early in the decade under pressure from external institutions.

The MOH budget levels, trends, and share of the national budget are shown in Table 3. The health sector received modest increments in its nominal budget over the 1980s. Moreover, between 1982/83 and 1986/87 health's proportion of the recurrent budget increased, although its share of the capital budget almost disappeared.¹ These shifts are indicated in Table 3. Despite some nominal increments, the real value of total resources available for health was seriously eroded between 1981/82 and 1985/86 falling from J\$172 million to J\$125 million in 1980 Jamaican dollars. Moreover, the devaluation disproportionately raised the cost of imported medical supplies and

1. Jamaican fiscal years begin in April and end in March of the following year.

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Table 3
 Ministry of Health Expenditures and
 Relative Budget Allocations, 1981-87
 (J\$ millions)

Budget Levels and MOH Allocation	1981/ 82	1982/ 83	1983 84	1984/ 85	1985/ 86	1986/ 87
<u>Government Budget</u>						
Total	186.50	200.50	203.40	235.90	290.80	n.a.
GDP deflator	1.08	1.19	1.38	1.88	2.33	n.a.
Total (real) ^a	172.38	168.71	147.83	125.79	124.80	n.a.
Per capita	84.53	89.20	90.70	102.50	125.80	n.a.
Per capita (real) ^a	78.13	75.06	65.92	54.66	53.99	n.a.
<u>MOH Budget as Percent of Total Budget</u>						
Total		7.50%	6.50%	6.30%	6.10%	6.50%
Capital		n.a.	n.a.	1.40	0.70	2.00
Recurrent		n.a.	n.a.	7.80	8.40	9.20

Source: Economic and Social Survey of Jamaica, 1986; Hospital Statistics Report, 1983.

a. 1980 is the base year (1980 GDP deflator = 100).

pharmaceuticals since these are largely import items, further reducing the spending power in the sector.

While the real value of public health resources declined, the allocation of those resources also shifted. In particular, with the expansion of primary health care (PHC) between 1982/83 and 1986/87 an increasing proportion of the budget was allocated to PHC. The budget share allocated to primary health care rose from 18 percent to 24 percent, achieved at the expense of hospital and support services budgets. The former declined from 69 percent to 64 percent of the MOH budget, and support services, which include laboratory, medical stores, maintenance and health education, fell from 6 percent to 4 percent. These declines occurred on top of the eroded value of the currency and resulted in dramatic reductions in purchasing power (Lewis, 1988).

Personal emoluments claimed between 56 and 60 percent of the total Ministry of Health's budget in the 1980s, although hospital-specific ratios ranged between 62 and 80 percent. Supply allocations, which include drugs, medical supplies, nonmedical supplies and maintenance, remained virtually stagnant over the three years, 1983/84 to 1985/86, although in proportional and real terms supply allocations were reduced. Simultaneously, the percentage of discretionary budget resources devoted to pharmaceuticals rose sharply during the same period, suggesting a necessarily marked reduction in expenditure on supplies and maintenance (Lewis, 1988).

Thus, the financial position of the public health system has seriously deteriorated fueled primarily by a rapid rise in the cost of nonlabor inputs and reduced real budgets in the sector. Exacerbating the financial strain was the expansion of the primary health care network, which coincided with the financial difficulties. The government's response has been to reduce all nonessential and fungible resources. Thus personnel costs have not declined

while those for supplies and maintenance have experienced a sharp drop, with negative implications for the quality of care in public hospitals.

V. COST RECOVERY POLICY

The financing of health care has emerged as a major concern of the government both because of the deterioration in the quality of health care and the inability to increase allocations to public programs due to the country's terms of agreement with the International Monetary Fund. The need to augment resources and improve the efficiency of public facilities has spawned a number of proposed reforms, some of which have already been implemented. Among the first was a revised fee schedule accompanied by radical reform of the traditional British public finance system that offered disincentives for the collection of fees.

User charges in Jamaican public hospitals have been in effect since the early 1960s, although fees were eliminated in 1972 and 1973. An updated fee schedule was introduced in 1984. Historically, fee collection was at best revenue neutral for facilities. All public revenues were placed in general tax receipt coffers (the Consolidated Fund) and hospital budgets were reduced by the amount collected (referred to as "appropriations in aid"). The policy reform measures accompanying the revised fee schedule in 1984 allowed facilities access to half of their collected revenues as an incentive for assessing and collecting charges from patients; subsequent adjustments allowed facilities to claim for the second half as well. The revised MOH financial arrangement required Cabinet approval and endorsement by the Prime Minister.

The radical departure from traditional financial practices, and involvements at the highest levels of government reflect the depth of financial

crisis, its effect on the public health system, and the necessity of taking extreme measures to rectify the systemic problems.

At the inception of the 1984 program, the Ministry indicated that facilities could retain 50 percent of all revenues and budget allocations would not be affected by revenue collection; however, confusion at the central level held this in abeyance until early 1985. The new 50 percent retention rule went into effect in January of 1985. Thus, at the start of the program, a number of facilities lagged in putting a collection system in place due to confusion and doubts regarding the permanence of the policy.

In order to retain central control over budgets, hospitals are re-allocated resources based on submitted budget proposals that allow release of funds already deposited with the Ministry of Health. The central Ministry of Health reviews the budgets for compliance with legal and policy requirements and then releases the funds. In 1987, the Ministry agreed to allow hospitals to claim for the second half of their revenues. Another detailed budget is required for the release of these revenues.

Table 4 summarizes the 1984 fee schedule for all public facilities, and indicates the allowable deviations from the standard schedule. In addition to prices for consultations, inpatient days, and ancillary and specialized services, the fee schedule stipulates that "patients covered by health/accident insurance policies shall pay the fees payable by private patients or the maximum payable under the terms of the policy, whichever is greater."

Charges in public facilities are modest in comparison with those charged by the private sector or even the University Hospital that receives grants from the government of Jamaica but has the freedom to set charges.² Thus, fees do

2. University Hospital applies a sliding scale of fees based on income. See Lewis (1988) for a comparison of fees across public and private facilities.

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Table 4

Jamaica's Public Hospital Fee Schedule
(Jamaican Dollars)

	Public Patients	Private Patients ^a
Outpatient/Casualty		
Registration fee	\$5.00/visit ^b	\$5.00/visit
Inpatient		
Admission - general	\$30.00/admission	\$50.00/day ^c
- intensive care unit	\$60.00/day	\$60.00/day
Maternity	\$50.00 ^d	\$150.00+
Use of operating theater	\$20.00-\$120.00	\$50.00/day ^e \$20.00-\$120.00
General		
Laboratory tests:		
single ^f	\$10.00	\$10.00 ^g
series ^h	50.00	50.00
X-ray Services		
single ^f	10.00	10.00
series ^h	20.00	20.00
X-ray Therapy	25.00	25.00
Physiotherapy (up to 6 treatments)	25.00	25.00
Blood transfusion	20.00	20.00
ECG	20.00	20.00
EEG	20.00	20.00
BMR	20.00	20.00
Appliances	25% of cost	50% of cost
Ambulances	\$15.00 for 10 mile radius plus \$.50 @ additional mile	\$30.00 for 10 mile radius plus \$1.00 @ additional mile
Dental Services		
Extractions	10.00	10.00
Prophylaxis & Filling	20.00	20.00
Dentures	50.00	50.00
International Vaccination Certificates	5.00	5.00

Exemptions:

-) All family planning-related visits
 -) All visits for immunizations
 -) Food Aid program registrants upon presentation of their green registration cards. (NB. Pregnant Food Aid Registrants will be charged delivery fees)
 - o Persons with high-risk pregnancies, as identified by the health team.
 - o Dental treatment for children already on the school dental program.
- a. Where a registered medical practitioner is attached to a rural hospital, he may be allowed to practice privately. In this case, he may also charge his private patients an additional fee—not exceeding \$600—as well as those fees specified below.
- b. A \$5.00 registration fee is paid once per year by patients with chronic conditions (diabetics, asthmatics, etc.). A \$5.00 prescription fee is paid each visit. Patients at 6 rural maternity centers (Issac Barrant, St. Thomas, Buff Bay, Portland, Ulster Spring and Falmouth) pay \$2.00/visit.
- c. Private non-Jamaican resident patients pay \$60.00/day as well as actual cost of drugs, appliances, and other services.
- d. The exception is obstetrical treatment (not full term pregnancy), charge is \$30.00 per admission.
- e. Private obstetrical patients at Victoria Jubilee Hospital pay only the \$50.00/day charge.
- f. A single x-ray or laboratory test is \$5.00 and \$10.00 respectively at Bustamante Children's Hospital.
- g. Individuals who are not patients at any hospital are charged \$20.00 for a single laboratory test.
- h. A series of x-rays or laboratory tests is \$15.00 at Bustamante Children's Hospital.

not come close to covering costs. What distinguishes these public charges from schedules in other countries, however, is the accommodation for private patients and the effort to collect from insurance companies.

Although charges are nominal, the new schedule and policy established a clear basis for allowing facilities to recover some portion of costs. The new fees and policy arrangement offer incentives to facilities to earn and collect charges, although they also provide incentives for intense use of services. The single charge for inpatients regardless of length of stay and the two tiered price for single and multiple laboratory and x-ray tests encourage patients to maximize their returns by extending the number of inpatient days or the number of tests. The differential between public and private charges are also quite modest and in some cases are identical, despite the fact that in some hospitals private patients have a single room, (more) private lavatory facilities and additional nursing services and other amenities. Moreover, from a cost recovery perspective, raising private patient costs would imply higher reimbursements from insurance companies since most private patients carry insurance.

Fees were set by the government according to perceived ability and willingness to pay, since costs of specific procedures or departments had not been measured, and no estimate of consumer demand was available. Moreover, since public facilities are used by a broad spectrum of Jamaican society, the government stipulated that patients covered by private insurance should reimburse public hospitals as they do private providers. Not collecting from patients effectively provides private insurance companies with a public subsidy.

Although the reform of the user fee system was aimed at raising the revenue of hospitals, the concern for equal access remained strong. The

accommodation for the indigent exempted all Food Aid recipients from being assessed; however, the need to exempt those who could not pay due to variable circumstances or chronic illness was also established, with the hospital held accountable to ensure that no Jamaican was turned away due to income constraints. Those officially exempted from paying fees currently include visits for family planning, immunizations, women with high-risk pregnancies, Food Aid recipients, children in uniform, and pensioners. Chronic illness patients pay a single annual registration fee.

VI. PUBLIC HOSPITAL REVENUES

Although fee levels and exemptions are specified neither the method of collection nor the thoroughness of collection are dictated by the central government, and these can and do affect earnings. Each facility has the flexibility to determine the nature and extent of fee collection efforts and the manner in which charges are collected. As discussed, since 1984/85, facilities have had an incentive to collect fees in order to supplement their operating funds. The retention and allocation of revenues has given hospital managers enhanced control over resources, providing strong managerial incentives for collection.

Total revenues from user charges are shown in Table 5 for fiscal years 1983/84 through 1987/88 for all public hospitals. With the exception of 1987/88, most facilities have incomplete monthly reports. The reported figures are calculated from the reported months and from averages of the existing months that are used to estimate a twelve-month total. Where less than five months of data are available, this is indicated in the table.

Table 5

Total User Fee Revenues for Public Hospitals
1983/84 - 1987/88^a

Hospital	Annual Fee Revenue				
	1983/84	1984/85	1985/86	1986/87	1987/88
<u>Type A</u>					
Kingston Public	n.a.	n.a.	1,248,620.03	1,193,281.60	1,534,426.20
Cornwall Regional	119,980.43	787,468.78	699,525.68	766,008.16	792,522.42
<u>Type B</u>					
St. Ann's Bay	n.a.	403,291.20	454,405.18	435,103.51	427,952.00
Sav-La-Mar	n.a.	173,472.00 ^b	128,102.74	117,030.86	197,083.00
Mandeville	n.a.	509,271.60 ^b	n.a.	502,062.48	545,212.30
Spanish Town	n.a.	333,790.54 ^b	433,669.64	618,245.77	774,148.30
<u>Type C</u>					
Princess Margaret	22,666.01	59,794.80 ^b	132,893.14	142,745.33	161,153.14
Port Antonio	8,806.09	40,978.65	96,888.33	114,178.15	137,412.30
Port Maria	n.a.	n.a.	115,882.40 ^b	105,292.80 ^b	n.a.
Falmouth	n.a.	77,929.39	88,886.13	104,467.64	92,747.52
Noel Holmes	n.a.	85,820.88	86,913.96	88,640.73	92,952.00
Black River	n.a.	124,788.00 ^b	112,193.93	113,571.43	175,692.00
May Pen	n.a.	114,838.90	150,532.91	133,992.54	131,916.00
Lionel Town	n.a.	94,359.84	99,565.33	92,753.33	87,951.00
Linstead	n.a.	101,413.85	141,448.49	168,331.47	153,160.00
Spaulding	n.a.	n.a.	211,150.00 ^b	141,943.20	154,317.00
Alexandria ^C	n.a.	76,260.00	57,333.60	35,016.00	54,960.00 ^b
Buff Bay ^C	n.a.	17,270.80	26,744.73	26,504.00	32,228.00
Chapleton ^C	n.a.	n.a.	171,656.00 ^b	n.a.	n.a.
Isaac Barrett ^C	4,286.66	n.a.	n.a.	n.a.	n.a.
Ulster Spring ^C	n.a.	11,821.33	17,712.00	11,920.80	10,200.00
<u>Specialty</u>					
National Chest	n.a.	64,650.45 ^b	113,729.26	67,519.31	144,735.00
Hope Institute	n.a.	9,469.20 ^b	34,262.41	16,045.47	16,254.67
Total^d	151,739.19	3,086,690.21	4,622,115.89	4,994,654.58	5,717,022.85

Source: Data collected by The Urban Institute.

- a. Data are based on hospitals' recorded monthly statements. Most hospitals have incomplete reporting and annual estimates were made by filling in missing months with an average for reported months. Those years for which four or fewer months of data are available are indicated. Reporting is most complete in 1987/88.
- b. Based on less than 5 months of revenue data.
- c. As of 1986/87 these facilities have been downgraded to polyclinics.
- d. Total reflects only the sum for hospitals reporting revenue. Hence, the figures are an underestimate.

Overall revenues are rising and most facilities are gradually increasing their revenues from fees. Policy changes in the 1984/85 fiscal years--despite the fact that the policy did not go into effect until the end of 1984--had a strong effect on facility earnings. For the few facilities with data for 1983/84, the increase in earnings between 1983/84 and 1984/85 was dramatic. The shifts are shown in Figure 1 for the three hospitals with available data for 1983/84: Cornwall Regional, Port Antonio, and Princess Margaret. These facilities' revenues jumped by 561, 1,460 and 611 percent respectively between 1983/84 and 1987/88, with the largest increase occurring the first year.

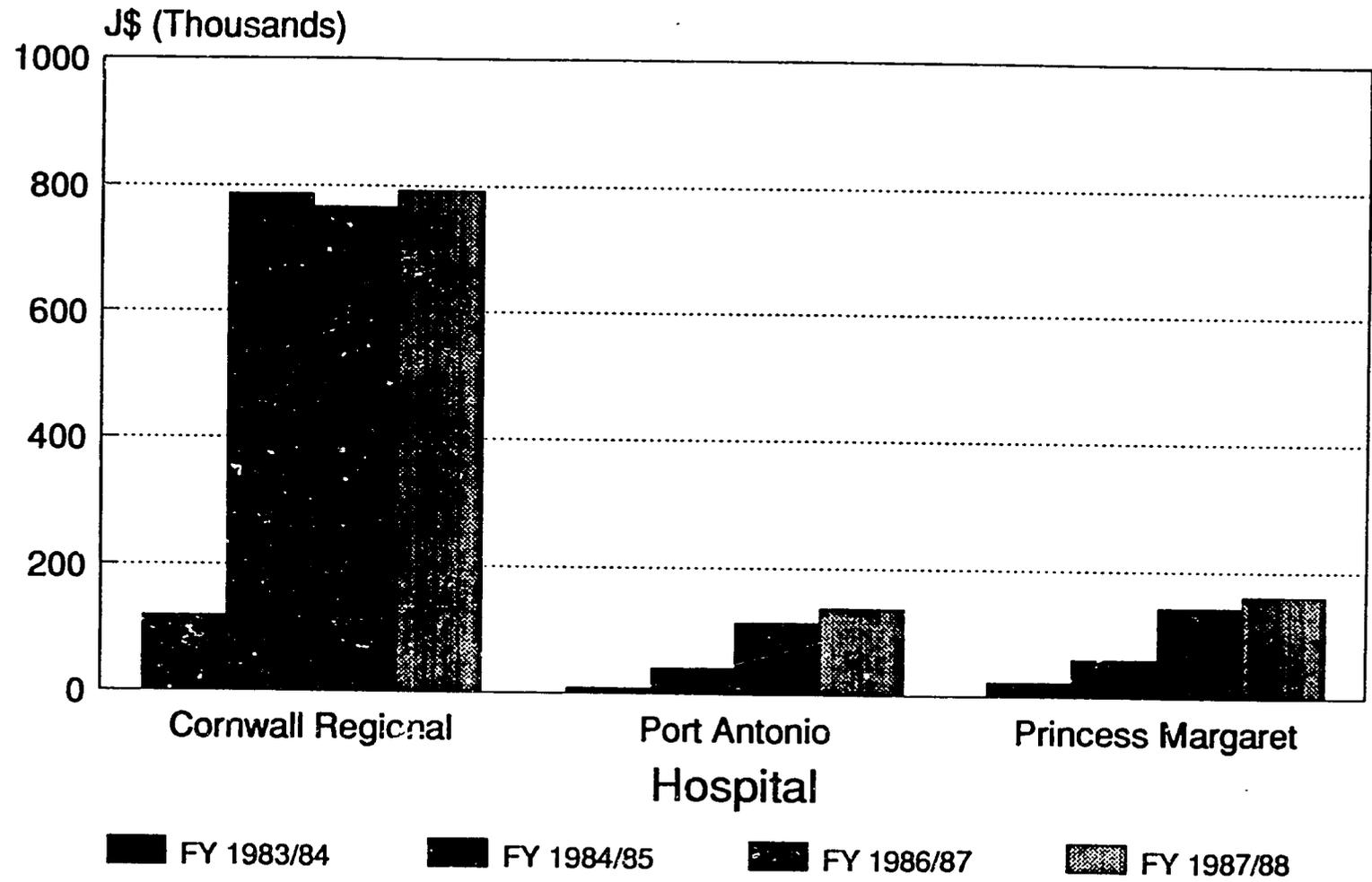
Over the subsequent years the level of earnings at the public hospitals has fluctuated. This may be due to the timing of revenue claims. For example, claiming 1983/84 earnings after the fact would be a rational strategy for hospitals since these claims could then be retained. Reneging on the promised retention of revenue may also explain a sharp rise in 1985/86 revenue and a subsequent decline in 1986/87 that again increased in 1987/88. If revenues were lumped into 1985/86, then the earnings in the following year would be likely to decline.

The novelty of the policy and the necessity of putting in place a system for collecting and tracking revenues took time in some hospitals, and therefore the pace of revenue earnings differs across facilities. The uncertainty of the policy, particularly after the central government initially recinded the agreement, added to some facilities' confusion and inaction. There is also the problem of ill-trained staff and managers who simply were unable to respond to the MOH's incentives. Together these factors suggest why the pattern of response in Table 5 is so inconsistent.

Chronic care facilities have particularly variable total earnings since charges are set on admittance and only ancillary services carry a charge; in

Figure 1

Total Fee Revenues Over Time



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addition, these hospitals have few patients. No daily charges are imposed, which places long term care facilities at a distinct disadvantage. Hence the earnings of National Chest and Hope Institute--the respiratory disease facility and the national hospice, respectively--fluctuate more than the other hospitals.

Adding to the difficulty of comparing trends are the private donations or community transfers that some facilities receive. Bustamente Children's Hospital, part of the Kingston Public Hospital (KPH) system, and KPH itself have fund drives sponsored by friends of the hospital. National Chest has received significant sums from grateful long term (private) patients, which further exacerbates the variability in earnings. St. Ann's Bay has received annual contributions for its private block from the local Chamber of Commerce since the hospital serves the tourist population of Ocho Rios. Thus although the most significant portion of earnings are from fees, some additional resources are obtained through private donations that augment the sums in Table 5 for some hospitals.

The trends in the proportion of the operating and total budget that fee revenue represents and in revenue earnings per patient also suggest increases overall with some variation across facilities. Nominal operating budgets for hospitals have increased somewhat between 1982/83 and 1986/87, as indicated in Table 6. In the aggregate, budgets have increased by 43.9 percent, with rises varying between 7.6 and 61 percent. This has occurred during a period when prices escalated almost 100 percent. The modest increases in some facilities' budgets and the eroding value of the allocation have resulted in reduced services, deterioration in the physical infrastructure, and efforts to raise funds from other sources. User fees have contributed to augmenting the budget, as have community and individual gifts.

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Table 6
Operating Budgets for Government Hospitals,
by Region, 1982-83 through 1986-87^a
(J\$ '000)

Region	1982-83	1983-84	1985-86	1986-87	Percent Change 1983/84 1986/87
All Regions	101,931	116,561	139,696	167,733	43.9
Kingston	29,867	32,949	40,819	53,067	61.1
St. Thomas	2,791	3,885	4,092	4,627	19.1
Port Antonio	3,372	3,894	3,997	4,171	7.1
Port Maria	4,080	4,591	5,468	6,211	35.3
St. Ann's Bay	4,203	4,685	5,997	6,435	37.4
Montego Bay	17,739	20,003	25,220	29,981	49.9
Sav-la-mar	6,799	8,371	8,479	10,167	21.5
Mandeville	5,858	7,049	8,069	9,940	41.0
Spanish Town	11,162	13,043	16,969	19,067	46.2
Liguanea	3,888	4,575	4,633	4,924	7.6
Bellevue	12,171	13,546	15,953	19,143	41.3

Source: Hospital Statistics Reports, 1983-1987.

a. Budget figures for 1984-85 not available.

Table 7 summarizes the proportion of the overall and operating budget that fee earnings represent, indicating the level of resources generated and the extent to which budgets have been supplemented in the first years under the new user fee policy. The figures are for regions rather than facilities because budgets are allocated on a regional basis. For those facilities with data for 1983/84, the growth has been rapid and the shift in the proportions dramatic, as shown in Figure 2 for the three regions (Montego Bay, St. Thomas, and Port Antonio). Unfortunately, the lack of budget levels for 1984/85 and 1987/88 limits the ability to assess the trends, but the ratios indicate a range of earnings relative to budgets for the initial two years under the new policy.

Mandeville region earned over 27 percent of its operating budget in 1986/87, the largest proportion of any facility in that year. Liguanea, Port Maria and Sav-La-Mar lag behind the other hospitals in revenues relative to their operating budgets in all years. Liguanea represents two chronic care facilities under a fee system that relies on admittance fees and only charges once a year for chronic outpatient care. Hence, the facilities currently do and will continue to underperform when compared to other hospitals. Port Maria and Sav-La-Mar serve lower income regions; however, these hospitals also are considered to be relatively less well managed, which may contribute to either indifference or inability to generate additional operating revenues.

Revenues per patient allows comparisons adjusting for case load and is shown on a facility basis in Table 8.³ Hospital revenue performance is more directly comparable on a per patient basis, and the figures suggest some considerable differences. In particular, the chronic care facilities generate considerable revenue on a per patient basis, and in some years are the most

3. Total patients are calculated using four outpatients as equivalent to one inpatient.

12a

Table 7

Fee Revenues, by Hospital Region as Percentage of Budget^a

Region	Revenue as Percentage of Total Budget			Revenue as Percentage of Operating Budget		
	1983/84	1985/86	1986/87	1983/84 ^b	1985/86	1986/87
Kingston	n.a.	3.1	2.2	0.0	13.3	9.8
Liguanea	n.a.	3.2	1.7	0.0	10.8	5.7
Mandeville	n.a.	2.6	6.5	0.0	11.1	27.4
Montego Bay	0.6	3.5	3.2	1.9	11.2	10.3
Port Antonio	0.2	3.1	3.4	1.2	16.7	18.2
Port Maria	n.a.	2.1	1.7	0.0	8.2	6.6
Sav-La-Mar	n.a.	2.8	2.3	0.0	9.0	7.2
Spanish Town	n.a.	5.9	5.3	0.0	20.4	18.5
St. Ann's Bay	n.a.	8.5	7.3	0.0	28.1	24.1
St. Thomas	0.7	3.2	3.1	3.6	16.9	16.0

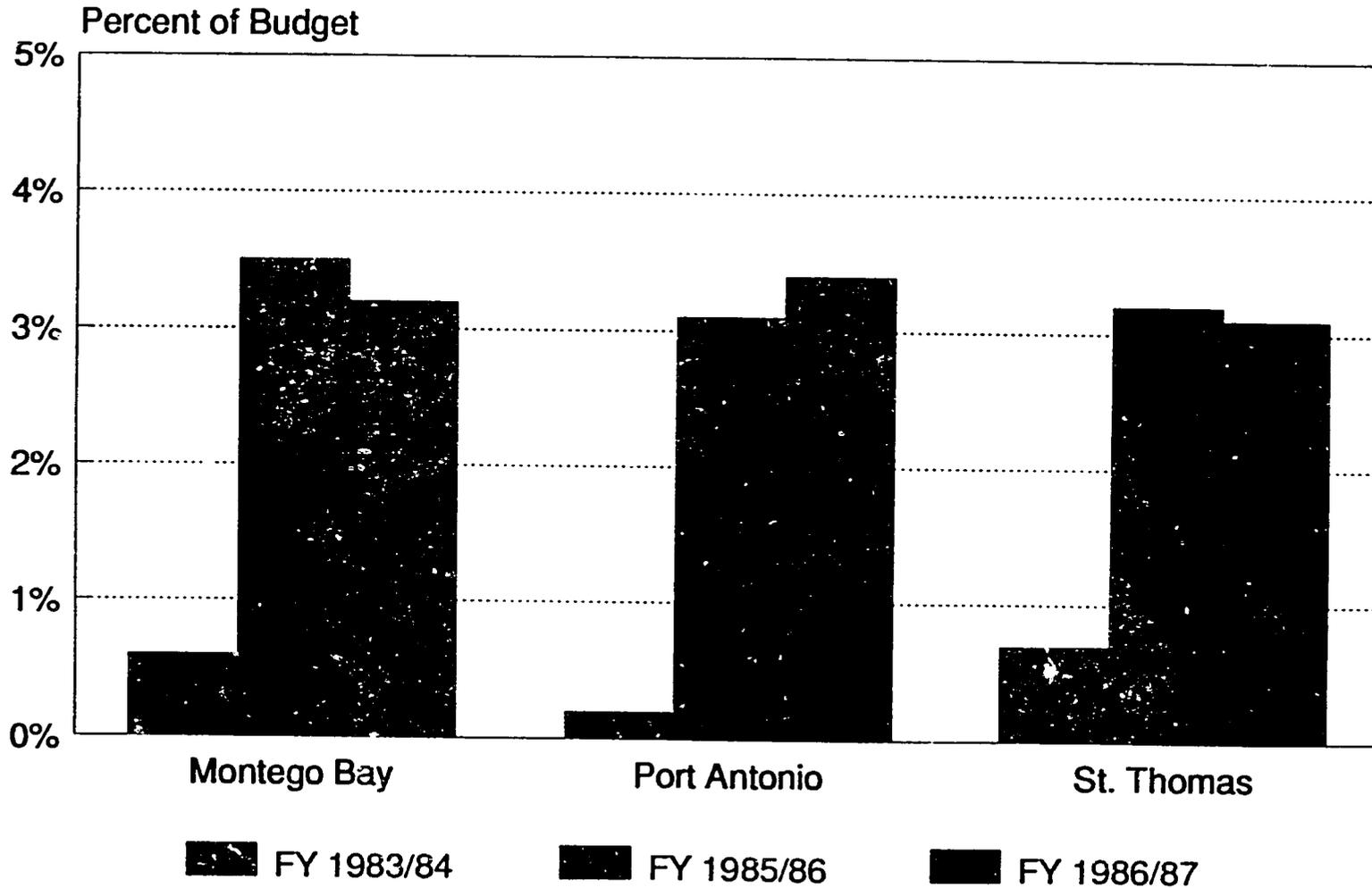
Source: Hospital Statistics Reports 1983-1986; data collected by The Urban Institute.

Notes: Budget figures for 1984/85 are not available.

- a. The proportion of the overall budget allocated to personal emoluments and operations for each hospital is based on actual proportions for 1985/86. These allocations are applied to each of the other years to estimate the relative importance of fee revenues.
- b. Revenues are only for the regional hospital in each region. Hence the revenue proportions are likely to be inflated.

Figure 2

Revenues as Percent of Operating Budget



12b

12C

Table 8

User Fee Revenues per Patient^a for Public Hospitals
1983/84 - 1987/88 (Jamaican Dollars)

Hospital	1983/ 1984	1984/ 1985	1985/ 1986	1986/ 1987	1987/ 1988 ^b	1987 (cal yr)
<u>Type A</u>						
Kingston Public ^c	n.a.	n.a.	\$35.44	\$32.89	\$42.00	n.a.
Cornwall Regional	\$9.33	\$55.26	\$60.51	\$70.84	\$71.52	\$47.64
<u>Type B</u>						
St. Ann's Bay	n.a.	\$56.19	\$60.83	\$57.87	\$54.23	\$48.72
Sav-la-Mar	n.a.	\$25.50	\$18.43	\$17.91	\$28.23	\$28.67
Mandeville	n.a.	\$72.13	n.a.	\$66.24	\$69.64	\$67.06
Spanish Town	n.a.	\$29.70	\$39.29	\$50.82	\$59.18	\$57.87
<u>Type C</u>						
Princess Margaret	\$4.93	\$14.56	\$30.34	\$27.69	\$28.55	\$27.69
Port Antonio	\$2.45	\$11.65	\$27.46	\$30.75	\$36.37	\$35.79
Port Maria	n.a.	n.a.	\$40.84	\$43.15	n.a.	n.a.
Falmouth	n.a.	\$27.13	\$33.17	\$39.66	\$35.61	\$23.09
Noel Holmes	n.a.	\$28.93	\$32.02	\$36.65	\$39.55	\$37.32
Black River	n.a.	\$26.75	\$26.32	\$25.18	\$37.65	\$36.86
May Pen	n.a.	\$34.28	\$53.55	\$41.77	\$41.30	\$40.52
Lionel Town	n.a.	\$38.34	\$62.68	\$177.55	\$42.09	\$37.40
Linstead	n.a.	\$21.82	\$36.80	\$59.87	\$61.43	\$56.64
<u>Specialty^c</u>						
National Chest	n.a.	\$42.79	\$105.46	\$66.90	\$136.44	\$155.23
Hope Institute	n.a.	\$46.99	\$197.31	\$75.53	\$86.46	\$103.60

Source: Hospital Statistics Reports 1983-1986; data collected by The Urban Institute.

Note: Data on number of patients is only available on an annual basis. These figures apply an estimate of patients using 75 percent of the patients in the first year and 25 percent of the following year's patients.

- Total patients are calculated using four outpatients as equal to one inpatient.
- In 1987/88 revenues are for FY 1987/88 but patient volume is for calendar year 1987. The last column uses annual data, thereby overlapping 1986/87 figures.
- Bustamente Children's Hospital, Victoria Jubilee Maternity Hospital, Mona Rehabilitation and Kiwanis are included in Kingston Public figures.

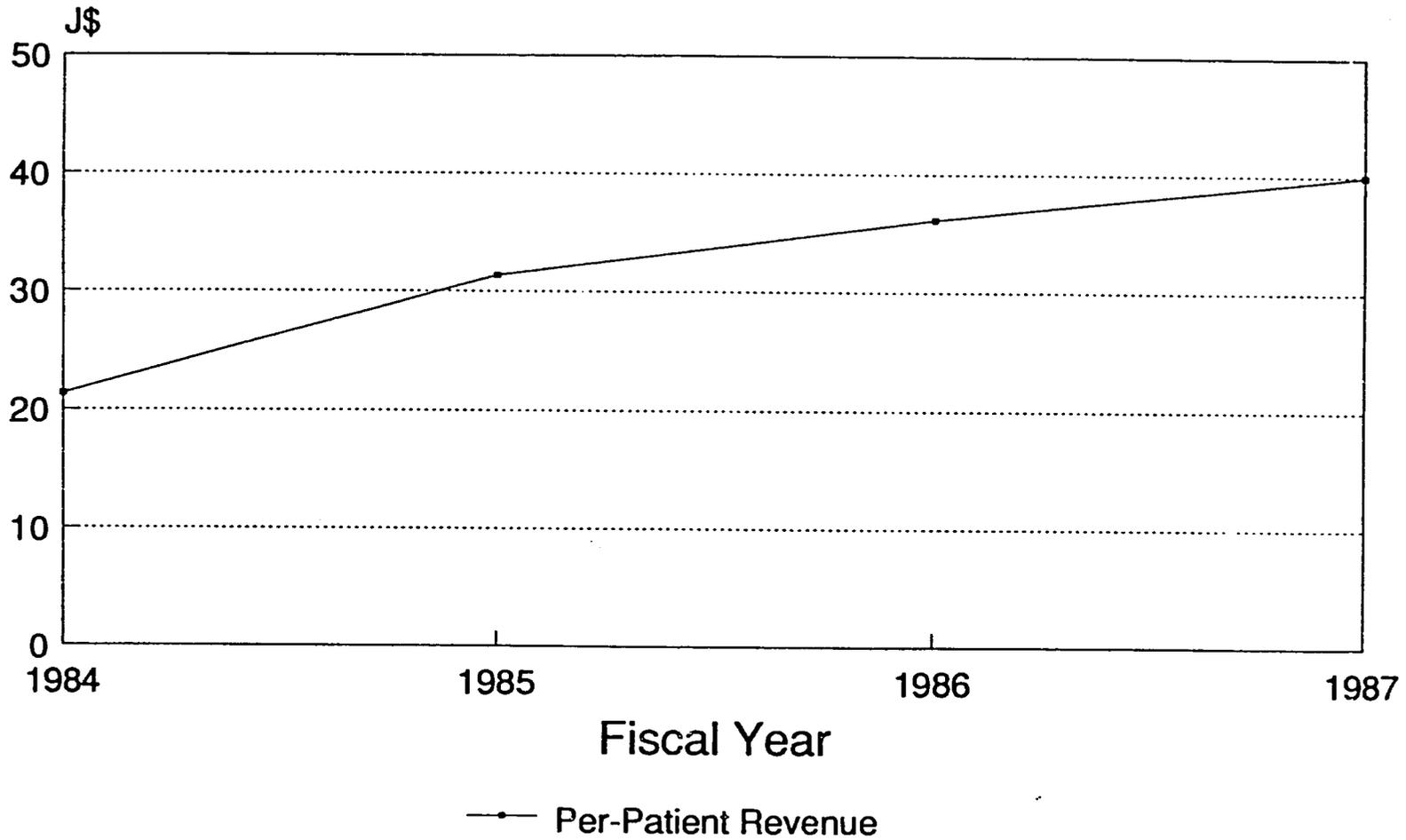
successful. In general there is an inverse relationship between the level and earnings of facilities, although KPH and Sav-La-Mar Hospital are exceptions. Cornwall Regional Hospital is the second highest absolute earner, but consistently the highest earner on a per patient basis of non-chronic care hospitals. KPH with the largest revenues performs relatively poorly and below all Type A and B facilities except Sav-La-Mar. Sav-La-Mar Hospital, however, performs below the other Type B facilities and near the bottom of hospitals at all levels.

Trends in per patient revenue vary in much the same manner as do the total revenues. The overall trend across all hospitals is shown in Figure 3 for 1984/85 to 1987/88. If data were available for 1983/84, the trend would show a stronger increase, based on evidence from the three facilities with earlier data. Because patient loads differ across facilities and patient numbers are generally declining per capita earnings growth deviates somewhat from those presented in Table 5. The rate of increase will necessarily be higher in the aggregate on a per patient basis since the majority of facilities have been losing patients during the 1982-87 period while overall revenues have grown by 85 percent between 1984/85 and 1987/88.

Lack of hospital-specific budget data may mask the success of various hospitals' approaches to fee collection. For instance both Cornwall Regional (Montego Bay Region) and Spanish Town Hospitals have made strong efforts to raise revenues through better management and fiscal control over fees, although the facilities within the region have not been as successful. Moreover, the case mix and severity of illness, which affects lengths of stay and the extent of diagnostic tests that are necessary, will also have an affect on costs. Since these are not included here they cannot be assessed, but these factors should be kept in mind as they impinge on the ability to generate revenues.

Figure 3

Average Per-Patient Revenue



Number of Hospitals with Missing Values:
1984- 2, 1985- 1, 1986- 0, 1987- 1

13/10

Although the system has performed relatively well and has generated significant revenues compared to previous years, the potential for enhanced improvements is considerable. In particular, the inability of hospitals to respond sufficiently to the new incentives is largely a question of management. More specifically, it is the inability or unwillingness to manage the fee collection system. Raising additional revenues can be achieved through improved design and oversight of the fee collection system as well as through adjustments in the fees themselves.

The single biggest management problem lies in the system of admissions and discharges, which in most facilities has historically been a casual process. Hospital discharges, for example, can occur anytime during a 24 hour period allowing patients to enter a ward without registering first or to leave without paying assessed charges because administrative staffs are only available during normal working hours.

Jamaica's treat first, pay later policy while important in emergency cases hampers collection and leaves facilities vulnerable to nonpayment by some patients. Indeed, noncollection was cited as a major issue by a number of hospitals. At Kingston Public Hospital and National Chest, administrators estimate that only about half of the eligible patients pay their (full) bill; however, much of this is nonpayment of post-service billing because patients were discharged without being requested to settle their accounts. Spanish Town and St. Ann's Bay Hospitals have hired assessment officers to tour the wards and private blocks to interview patients, determine who has insurance coverage, and check for compliance. Most facilities, however, rely on physician referral of private outpatients to registration and accounts, which is generally an ineffective arrangement.

Another area that has been neglected is that of insurance claims. Despite stipulations to the contrary (see Table 4 for the full fee schedule), insured patients are typically charged only the private patient fee as opposed to the public patient charge. Insurance claims are filed for private patients, but these are well below the maximum reimbursements companies make to private health providers. In addition, most Jamaican insurance companies have an annual ceiling on the amounts they will cover in a given year. Hence users have an incentive to husband these resources in case of serious illness. More importantly, however, because private insurance generally does not include catastrophic coverage, any long or serious illness is ultimately treated gratis in public hospitals (Lewis, 1988). In effect, public hospitals are not taking advantage of the reimbursements insurance companies already make, although they are subsidizing the care for many insured patients when the costs of an illness or health problem rise sharply.

The extent of cost recovery is seriously hampered by the fact that charges do not cover a significant fraction of the cost of care. In addition to the underclaiming from insurance companies, fees are also quite low. This is especially true for private patients. Reform issues are discussed below under Recommendations.

VII. SOURCES OF REVENUE

Where hospitals earn revenue is important to both revising collection systems and, to some extent, prices. Data for 1985/86 for most public hospitals are presented in Table 9. Data for this year is the most complete, and in most cases the distribution of revenue sources is typical for the unreported three or four years for which there are data.

Table 9
Sources of Hospital Revenues, 1985-86

Hospital	Estimated Total Revenue	% Admission	% Out- patient Registr.	% X-Ray	% Lab	% Maternity	% Drugs	% Other
Type A								
Cornwall Regional	\$ 699,526	23.2%	19.1%	12.2%	8.1%	14.9%	14.9%	7.6%
Type B								
St. Ann's Bay	454,405	17.1	10.1	9.2	6.2	13.2	16.3	27.9
Sav-la-Mar	128,103	16.1	6.2	8.2	1.4	36.2	12.1	19.7
Mandeville ^a	209,193	21.4	13.1	8.7	11.1	17.5	14.1	16.3
Spanish Town	433,670	46.8	10.2	8.5	8.5	0.0	21.2	4.8
Type C								
Princess Margaret	132,893	13.6	3.8	10.0	11.8	34.2	16.6	10.0
Port Antonio	96,888	6.5	3.8	9.0	10.0	29.1	27.8	13.8
Port Maria ^b	115,880	11.4	18.7	1.3	5.2	29.7	25.0	8.7
Falmouth	88,813	16.1	8.1	15.0	8.5	24.5	11.1	16.5
Noel Holmes	86,914	14.8	4.7	13.9	6.0	35.7	6.6	18.3
Black River	112,194	13.9	18.6	0.0	2.3	31.8	19.3	14.1
May Pen	150,533	33.9	9.0	20.5	6.7	0.0	29.5	0.3
Lionel Town	99,565	45.3	27.0	0.0	1.8	0.0	24.0	2.0
Linstead	141,448	48.7	9.1	15.7	0.0	0.0	26.4	0.1
Alexandria	57,334	1.8	15.9	0.0	0.0	25.1	30.3	26.9
Buff Bay	26,745	7.4	16.3	0.8	0.1	33.6	30.7	11.1
Chapleton ^b	171,736	58.4	9.2	0.0	0.0	14.4	11.9	6.1
Spaulding ^b	211,150	5.7	2.7	3.8	7.2	14.6	57.2	8.8
Ulster Spring	17,712	7.5	16.6	0.0	0.0	32.4	38.3	5.2
Specialty								
National Chest	113,729	5.8	1.4	8.5	1.1	0.0	14.5	68.7
Hope Institute	34,262	100.0	0.0	0.0	0.0	0.0	0.0	0.0
Maternity Centers								
Newell	9,998	0.0	0.0	0.0	0.0	100.0	0.0	0.0
Fair Prospect ^c	2,280	0.0	0.0	0.0	0.0	100.0	0.0	0.0
Weighted Average^d	\$3,385,778	25.6%	11.4%	8.7%	5.9%	14.9%	20.6%	12.9%

Source: Data collected by The Urban Institute from MOH files.

a. Data are for 1986/87.

b. Based on three months of data.

c. Based on a single month of data.

d. This total excludes facilities that have not reported revenue by source, such as KPH, the highest earning entity.

The source of facilities' revenues varies markedly due partly to the nature of each facilities' services as well as to their size. In addition, there are discrepancies in source definitions. On average, inpatient admissions earn the largest amounts; however, the four Spanish Town Region hospitals have counted maternity charges as admission fees. Hence Lional Town, Linstead, May Pen and Spanish Town Hospitals have no maternity earnings, despite the fact that both May Pen and Spanish Town have a well over 100 percent occupancy rate in their maternity wards, and admissions are a disproportionate source of revenue.

Drugs are a consistently important source of revenue for most facilities, and their importance remains across time. The smaller, recently downgraded (rationalized) facilities, Alexandria, Buff Bay, Spauldings and Ulster Spring Hospitals, rely most heavily on drug charges for their revenue, followed by maternity fees. Type A hospitals are least reliant on maternity, and benefit most from admission fees. The "other" category most commonly includes, morgue, dental, physiotherapy, and operating theater revenues. St. Ann's Bay, Alexandria, and National Chest Hospitals, however, have the largest allocations to "other," reflecting their heavy reliance on private patients, which accounts for 12.7, 21.2, and 65.0 percent of each hospital's revenue, respectively.⁴ All three hospitals have private wings with upgraded services. St. Ann's Bay Hospital also has an augmented fee schedule of J\$100 per day for Jamaicans and J\$200 per day for tourists.

X-ray and laboratory services generally are not important sources of income. This is partly due to the difficulty of tracking and charging patients

4. The proportion National Chest Hospital earned from their private wing exceeds the average proportion in other years by at least a factor of two. The 65 percent probably reflects charitable donations from private patients.

for these services. Moreover, some facilities (National Chest and Spanish Town Hospitals) do not charge inpatients for ancillary services as a matter of course. Laboratory and x-ray charges in private hospitals are a major source of income in private hospitals in the U.S. and Jamaica (Lewis, 1988), and could become more important if appropriate charges were in place.

Cornwall Regional Hospital has the most even distribution of revenue sources. They also have a strong management team and established operating systems for assessing and collecting fees. Patients must present receipts to the ward nurse, at the pharmacy and at x-ray, and whether or not the patient has made their payment is entered into their medical record. Cornwall Regional Hospital's earnings are high and their per patient revenue the highest among all facilities, which may be due to their systematic approach and consistent collection.

These patterns suggest that strengthened leadership and financial management are associated with earnings levels. Moreover, private wings should be considered for other public hospitals, although additional information on the elements that result in establishing and operating successful private blocks. Moreover, the cost of these augmented services may result in a net loss, despite the positive impressions suggested by the information in Table 8. Secondly, improved management and oversight of fee collection as well as an organized system for ensuring payment appear to be essential to raising overall revenue.

Table 10

Allocation of Revenue Expenditures, FY 1986/87
(Jamaican Dollars)

	Estimated Annual Expenditure 1986/87 ^a	Percent Allocation of Expenditures, 1986/87					
		Drugs	Supplies	Mainte- nance	Equipment	Salary	Misc.
Type A							
Kingston Public ^b	159,795	0.0%	28.8%	68.5%	2.7%	0.0%	0.0%
Cornwall Regional	382,744	0.0	7.6	88.9	2.2	0.0	1.2
Subtotal ^c	542,539	0.0	13.8	82.9	2.3	0.0	0.8
Type B							
St. Ann's Bay	375,601	27.2	5.7	41.5	4.9	22.4	0.0
Sav-la-Mar	60,511	0.0	0.8	95.9	3.0	0.0	0.3
Mandeville	248,047	5.2	1.6	56.4	35.4	0.0	1.3
Spanish Town ^d	484,622	0.0	14.1	17.8	68.1	0.0	0.0
Subtotal ^c	1,168,781	9.8	8.1	37.7	37.5	7.2	0.3
Type C							
Princess Margaret	75,323	0.0	1.2	98.8	0.0	0.0	0.0
Port Antonio	57,418	0.0	0.0	99.6	0.4	0.0	0.0
Port Maria ^d	57,333	0.0	0.0	93.0	7.0	0.0	0.0
Falmouth	51,127	0.0	0.0	94.9	5.1	0.0	0.0
Noel Holmes	41,801	0.0	0.0	100.0	0.0	0.0	0.0
Black River	110,721	0.0	5.4	93.3	0.0	0.0	0.0
Spauldings	59,277	7.4	18.4	72.8	0.0	0.0	1.3
Subtotal ^c	453,000	1.0	3.9	93.1	1.5	0.0	0.5
Specialty							
Victoria Jubilee	111,267	0.0	41.9	30.0	28.1	0.0	0.0
National Chest ^e	61,030	0.0	20.2	79.8	0.0	0.0	0.0
Bustamente	109,477	0.0	21.9	77.2	0.0	0.0	0.9
Subtotal ^c	281,774	5.2	10.3	59.1	21.5	3.7	0.5
All Hospitals	2,446,094	4.9	11.0	60.4	20.0	3.4	0.5

Source: Data collected by The Urban Institute from MOH files.

- a. Some hospitals have incomplete data for FY 1986/87. An average of the included months was used to produce a 12-month expenditure estimate.
- b. Subtotals are weighted averages of the facilities within facility type.
- c. Includes expenditures at Kiwanis and Mona Rehabilitation.
- d. Regional allocation.
- e. Includes expenditures of Hope Institute.

VIII. ALLOCATION OF FEE REVENUE

Expenditure of revenue lags behind earnings because of the necessity of depositing to and claiming earnings from the Ministry of Health. Some regions claim monthly (Montego Bay), while others wait until the end of the fiscal year to claim all earnings (Spanish Town); still others have adopted a random claim process. The sooner claims are submitted the higher the annual expenditure, especially since this is a relatively new arrangement. Given the differences in levels and the fact that the timing of claims is so different across facilities, it is more useful to examine the percentage allocations across major expenditure categories. Expenditure of hospitals' fee revenues suggests the importance of charges to public hospital operation and more importantly to the quality of service.

The level and allocations of revenue for 1986/87 are shown in Table 10 for all hospitals. The bulk of these funds are allocated to maintenance, which encompasses fixing buildings, plumbing, furniture (e.g., chairs, beds, mattresses) and equipment, painting, wiring, and improved security; and supplies, which includes purchases of sheets, gloves, x-ray film, reagents, uniforms, and so forth. These purchases are viewed as emergency expenditures by the hospital managers who have been unable to undertake the most basic of purchases in recent years.⁵ The affordability of fundamental maintenance and purchase of supplies are currently tied to fee revenue, and this is likely to remain the case given economic circumstances. Overall, 60 percent of fee

5. Serious examples of the extent of neglect are facilities' inability to repair buildings and equipment following accidents (e.g., fire, flooding), breakdown of basic infrastructure (e.g., water, heat, electricity), or vandalism, which hampers production and in some cases shuts down whole wings or units in the hospital.

revenue goes for basic maintenance; in the Type A hospitals it is almost 83 percent, and reaches 93 percent in Type C hospitals.

Some hospitals are allocating revenues to establish private wings to attract insured and better off patients (e.g., Port Antonio Hospital), but the opportunity cost of this strategy is high given other demands, which partly explains the slow progress in this area. Equipment, supplies, drugs, and fee collection personnel ("salary" in Table 10) account for a smaller proportion of the expenditures.

Despite the relatively modest level of expenditure, on the margin, the additional revenues are key to continued operation of public health facilities. The investments these resources allow are critical to maintaining the most basic level of services. Moreover, the expenditures are instrumental in enhancing worker productivity because the environment is more appealing and the non-labor inputs are more likely to be available.

IX. MEANS TESTING

Reluctance to charge at public facilities is commonly based on a concern for equity and the need to subsidize care for the indigent. In other words, the fact that some segment of the population requires financial assistance to obtain health care has translated into the full subsidization of health care for all citizens. User fees are not incompatible with government's desire to ensure access to health care regardless of patients' ability to pay. The Jamaican Ministry of Health's design of user charges directly addressed the

need to ensure equal access to health services while generating resources to contribute to public hospital operation.⁶

Under the revised fee system charges are waived for Food Aid (food stamp) recipients, pensioners, and children in uniform. In addition, individuals who indicate an inability to pay can be exempted from paying. This system is operating successfully in the Jamaican public hospitals.

Of relevance to the necessity and extent of waivers in Jamaican public hospitals is a recent study, which indicates that a large proportion of individuals seek care in the private sector (McFarlane and MacFarlane, 1987). In 1987, the vast majority of ambulatory health care services were purchased outside the public health system. For example, the proportion of the population in eight parishes seeking care from a public clinic for their last illness ranged from only 8.6 to 19.8, and this excluded the affluent Kingston-St. Andrews parish. Thus there is an ability and willingness to pay for outpatient care to a considerable extent.

For inpatient care the data indicate an inability or less willingness to pay for private care. Indeed, private hospitals report a large proportion of insured hospitalized patients, suggesting the importance of insurance if government cannot cover the full cost of hospitalizations (Lewis, 1988). This pattern suggests that patients can contribute to cost recovery in public facilities but cannot afford the full cost of inpatient services. Data on the number or rationales for waivers are not collected by hospitals.

Estimates by hospital directors and assessment officers of the proportion of patients who pay fees range from less than half at National Chest Hospital

6. Evidence from the Dominican Republic (Lewis, 1987) and Honduras (1987) shows a similar two-tiered pattern where those who can pay and the indigent have their charges waived.

(NCH) to 55 percent at Port Antonio Hospital to 65 percent at KHP and Cornwall Regional to 70-75 percent at Spanish Town Hospitals (outpatients only).

Implicit waivers are also offered in some facilities (e.g., NCH) as the hospital does not charge inpatients for laboratory or x-ray services.

Discussions with hospital management and assessment officers suggests that the current criteria for waivers over-subsidizes, and that there is a greater ability to pay the modest charges among Food Aid recipients than is assumed by the government. For example, anecdotal evidence indicates that Food Aid recipients may be purchasing prenatal services on the private market only to then deliver their babies free of charge in public hospitals. An indepth evaluation of this issue is warranted to improve the fairness and effectiveness of user fees.

Thus the Jamaican government's user fee system has been set up to accommodate the indigent and appears to be operating appropriately. The lack of hard data and of information on the current use and purchase of health care among various income groups, however, seriously hampers any assessment of the fairness and scope of the current means testing procedures. Stronger evidence on this issue could assist in redefining eligibility for waivers and for setting the maximum fees affordable at different income levels.

X. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Government policy toward user charges matters a great deal in terms of earnings and fee incidence. Incentives for collecting fees can raise revenue earnings dramatically. Where government policy established user charges in

Jamaican public hospitals and required that revenues be deposited in central coffers, earnings represented between 1 and 4 percent of budget allocations. Once hospitals were allowed to retain (some of) the revenue, earnings increased to between 6 and 28 percent of hospital operating budgets. Indeed over the three years of the new policy and fee structure, earnings grew by over 500 percent in most hospitals.

Revenues earnings have been respectable even though hospitals have only charged between half and three-fourths of all patients. Means testing is taken seriously and appears to be enforced with regularity. Anyone on Food Aid, retired or otherwise unable to pay is exempted from the MOH fee schedule.

Revenue earnings have been allocated to compensate for real and nominal cuts in maintenance and supply budgets. The allocation of revenue has been to essential inputs, and the vast majority of funds are spent on maintenance. In a few facilities, revenues are allocated to cover salaries of collection staff. These resources have been important to keeping hospitals functional, and are a key means of enhancing and maintaining quality as real budgets continue their sharp decline.

While revenues have risen sharply, the potential for greater earnings is significant. Moreover, given the high marginal value of these revenues to hospital operation, the inadequacy of government budget allocations, and the continuing need for fungible resources, enhancing cost recovery is essential to the provision of care.

Fees have made a significant difference in hospital operation, all facilities have some established method for collecting fees and most are attempting to improve and expand efforts. The outstanding difficulties are devising foolproof methods to ensure that patients who can pay do so, maintaining quality in public and private wards to earn the fees, and improving

the fee structure to more closely cover costs for patients with insurance or with sufficient resources to pay full fare.

Recommendations

Collection and Compliance. Greater efforts could be made to educate nursing and medical staff about the need to ensure patient payment at every stage of treatment. This may involve establishing systems that require assessment/payment prior to reaching treatment stations (i.e., arrangements where stamped tickets or vouchers are required). This may also entail personnel to track and enforce such procedures. Experimentation with different collection and monitoring procedures across hospitals would be useful to suggest cost effective means of cost recovery. Workshops among managers to assess successes and failures of alternative hospital systems could also be used to assist facilities to improve their collection arrangements.

Administration of User Charges. Currently, hospitals are required to send all proceeds from user fees to the Ministry of Health (MOH). They can be reimbursed only after submitting a fairly detailed request to the Ministry. This system appears to be unnecessarily cumbersome, especially since revenues from user fees are typically used for urgent maintenance work and purchasing of supplies. Moreover, allowing hospitals greater control over their revenues, should result in considerable savings in administrative costs.

If the MOH must remain accountable for hospital expenditures, then an alternative to the current system might be an arrangement whereby some facility autonomy could be extended by only requiring that, say, 25 percent of revenue be returned to the Ministry. Then submitted budgets could be approved and any inappropriate expenditures disallowed through retention of the 25 percent that

would otherwise be reimbursed. In addition to being cost-effective, this would allow hospitals to address needs more immediately.

Standardized MOH reporting forms could clarify for hospitals what information is needed to assist the MOH in tracking funds, and the forms could be used for monitoring. The Ministry's plan to computerize the fee revenues and expenditures should be encouraged and assisted, as this too would assist monitoring.

Reform of User Charges. The user charges that went into effect in 1984 have not been adjusted since, although inflation has eroded their value. The current fee system offers incentives for long lengths of stay and disincentives for prudent use of laboratory and x-ray services. Moreover, the current exemption criteria appears to encompass patients able to pay the modest fees. Private patients and those with insurance are currently being unnecessarily subsidized by the government since both can and do pay more at private facilities.

A number of adjustments could help to raise and improve the fairness of hospital fees:

- introduce modest per inpatient day charges to discourage excessive lengths of stay;
- institute per test charges for x-ray and laboratory services for both inpatients and outpatients;
- reassess exemptions, perhaps establishing a sliding scale, and subject current exemptions (e.g., those for food aid and pensioners) to a means test. For instance, all pensioners are not destitute, and those who can afford fees should be charged.
- private patients should pay a larger portion of costs, as should patients who carry insurance. Establishing fees similar to those of the University Hospital could be implemented for private patients and is easily monitored by hospitals.
- private wings need to be upgraded and the amenities and environment enhanced to attract patients. Promoting these specialized services could also help to raise utilization of private wards.

- 25 -

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