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THE HOSPITAL USER FEE EXPERIENCE
IN THE DOMINICAN REPUBLIC

October 1987

Resources for
Child Health
Project

REACH



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**The Hospital User Fee Experience in the
Dominican Republic**

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ABSTRACT

The public hospitals in the Dominican Republic are increasingly squeezed financially due to frozen operating budget allocations from SESPAS. User fees are one of the options hospitals are using to cope with reduced resources from the ministry. This study of 10 SESPAS facilities from all over the country, 9 hospitals and the National Laboratory, examines user fee policy, the fee structures of the sampled facilities, and the revenues from fees, the allocation of revenue, and the means tests applied in each facility.

Policy toward fees in public facilities is ambiguous for outpatient services but prohibited for inpatient facilities. All of the sampled institutions have fees for outpatient services, and these vary considerably across facilities, because each facility has designed its own unique system. Only Jose Maria Cabral y Baez Hospital has a private wing where upgraded housekeeping services are provided.

User fees are providing the largest proportion of additional resources for hospitals' operating budgets, followed by debt and charity. In 1986, fees contributed up to 70 percent of all operating expenses (excludes all personnel expenditures), although typically the proportion was closer to 20 percent. Moreover, revenues from fees are rising rapidly and if the trend continues will become an increasingly important source of operating funds.

Funds are most frequently allocated to purchasing pharmaceuticals, with personnel, maintenance and supplies close seconds. Other expenditures include food (to feed both patients and staff as required by law), equipment, and construction. One hospital supplements the gastroenterology department's budget with almost 70 percent of its revenue. Thus the allocation of discretionary revenue allows the purchase of essential inputs, which are the marginal contribution that permit facilities to function properly, or in some cases at all.

Means tests by hospital social workers allow a screening method to waive fees or provide discounts to patients who cannot pay or who cannot pay the full price. Although data for most facilities is poor, roughly about half of all patients pay nothing or only some portion of the established charges. The combination of discount and waiver varies across facilities, with some requiring at least some nominal payment. Thus there is a means of not charging those who cannot pay, which is in keeping with the government's commitment to pay for health care if households cannot afford to pay.

Fees are an increasingly important element in medical facility budgets. Improved efforts to earn revenues from fees should consider the following: tying fees more closely to costs; imposing fees for every service, however nominal; and, setting charges for high volume services, again, even if they are modest. Most important, however, is the need to consider charging for inpatient services, since these are the largest share of the hospitals' budgets, outpatient care is more likely to be preventive, and the current incentive structure encourages patients to enter through emergency or inpatient care for basic tests or simple treatments.

Thus a functioning user fee system is already a reality in Dominican medical facilities, although the central government has neither promoted nor assisted the effort. Refinements of the current approach could be achieved through better incentives to hospitals and assistance in devising more efficient fee systems.

Table of contents

	Page
.....	
Introduction	1
Circumstances in the Dominican Republic	4
Government Policy Toward User Fees	5
The Public Health System	6
Data	7
User Fees in Hospitals	8
Outpatient Services.	8
Inpatient Services.	10
Sources of Medical Facility Resources	13
Trends in Medical Facility Resources	15
Expenditure of Revenues	19
Means Testing	23
Conclusions	24

Introduction

Much of the developing countries' public health systems have been built on the premise that health care is a fundamental right, the state must meet the health needs of the population, and public services should be free. Concerns over equal access and affordability have further enhanced the appeal of free-service policies. Despite the desirability of ensuring access to health services, recent economic events have made it clear that such policies are unaffordable over the long term for much of the developing world. The outcome of the 1987 World Health Organization's World Health Assembly has concluded as much.

Public health systems are costly, both because of the inherent inefficiencies in public health care delivery (Lindsay, 1975; PPSS, 1984), and especially where the subsidy net encompasses the entire population. Where services are free there are no built-in incentives to discourage utilization, outside of patients' time. Thus, building a health care infrastructure is costly, but operating a free, open system is staggering, especially for a high recurrent cost sector such as health.

The financial crisis facing the health sector in many developing countries is not entirely due to a commitment to costly and broad social service coverage, however. The world-wide recession of the early eighties, falling prices for primary products, and the emerging debt problems of developing countries have contributed as well. Requirements to reduce government spending in order to reschedule debt repayments have forced governments to cut back on expenditures in all sectors, including health. Indeed, between 1972 and 1983, government allocations to health dropped to 4.5 percent of total budgets (Griffin, 1987).

Despite the fiscal crisis, a commitment to subsidized health services for those unable to pay for care remains in many countries, including the Dominican Republic. However,

reductions in resources means facilities deteriorate or resources must be concentrated on a few facilities or services, unless alternative sources of funds can be identified. The need for additional resources, due to both decreases in funding and growth in demand has led a number of governments to exam alternative methods for sharing costs with patients.

Cost sharing can involve private third party payers (insurance companies), government insurance, health services as an employee benefit, or user payments. Costs can also be reduced through improvements in productivity, but these are not addressed here. User fees are conceptually simple, require minimal administration and regulation, and can demonstrate effectiveness in a short time (See Bekels and Lewis, 1985). User charges are becoming of increasing interest to governments that want to subsidize care but cannot afford free health care for all services or for all citizens. Difficulties with user fees emerge with regard to what services should have charges, how prices should be set, who should pay them, how they should be administered, how revenues should be allocated, and the means and results of exempting patients who cannot afford to pay.

While a number of countries have traditionally set fees in public hospitals, some have been more successful in raising revenues than others. Typically the percent of recurrent costs recovered through user fees ranges between 2 and 17 percent, with the vast majority of countries at the lower end (Ainsworth, 1984; de Ferranti, 1985). Detailed evidence from Sudan (Bekele and Lewis, 1986), Rwanda (Shepard, Carrin and Nyandagazi, 1987), Ethiopia (Dunlop and Donaldson, 1987) and Honduras (Overholt, 1987) suggest that fees can generate significant resources at all levels of the health care system even without an articulated policy or a centrally imposed user fee system.

The issue of the benefit of fees is not only that they can generate significant resources for facilities providing care, but also that the marginal benefit from these resources can raise quality significantly. For instance, if fee revenues are allocated to purchasing simple inputs such as bandages, syringes or x-ray film, or can allow the hospital to fix a leaking roof, the

marginal value of these inputs is extremely high. As the proportion of government budgets allocated to salaries rises or remains constant, the marginal benefit of fees also increases since stagnant or falling overall budgets require a reduction in operation, maintenance, and asset replacement funds. Thus the marginal value of the user fee revenue may be of great importance even if the revenues are modest. Moreover, fundamental improvements in either the physical environment or the availability of supplies -- two areas of particular need in public health facilities of most developing countries -- can affect productivity. In effect, fee revenues serve as an incentive for workers through upgrading working conditions and enhancing their productivity because complementary inputs such as equipment and supplies are more consistently available.

The success of user fee systems, that is their effectiveness in generating revenues for the health system, is tied to the incentives hospitals face for collecting fees. First, it is essential that central governments either endorse or at least do not prohibit fees at public health facilities. Second, fee collection must be in the interests of the hospital, otherwise the hospital will be expending its own scarce resources to raise general government revenues. The latter is increasingly acknowledged as a problem. Jamaica, for example, has recently modified its traditional system of submitting revenues to the central government and is experimenting with allowing hospitals to retain some of the revenues as a means of enhancing hospital incentives to raise revenue from patients (Lewis, forthcoming).

The equity concerns associated with the imposition of user charges remain an issue for many governments because the target group for public services is often perceived as unable-to-pay for health care. But the poor already pay much more for private care than the amounts required given fees at public facilities (de Ferranti, 1985). Despite this, governments have historically preferred to ensure access to free care to those whose income is sufficiently low that they should not be expected to pay. But the method for achieving the goal is a wide open system that provides services to anyone who does not want to pay.

For systems that do have means tests, the income cut-off and the method of exemption varies by country. In the Sudan, free services were supplemented by various subsidized fee-for-service alternatives for those able to pay something (Bekele and Lewis, 1986); in Jamaica food stamp recipients, some preventive services, high-risk pregnancies and some childrens' dental care services are exempt (Lewis, forthcoming); a number of Latin American and Caribbean countries have social workers who screen patients for their ability to pay (Lewis and Overholt, forthcoming). While cumbersome and often highly porous, these systems allow governments to both apply charges and yet meet the needs of a narrower target group. How effective such systems are is not known, but they represent an attempt at segmenting the market and narrowing the eligibility for subsidies, and therefore should reduce costs, *ceteris paribus*.

This study examines many of these issues within the context of the Dominican Republic's user fees experience in public hospitals between 1984 and 1986. The study concentrates on the fee history, the different fee systems of hospitals, the resources generated by fees, the allocation of those revenues and the means of accommodating patients who cannot pay.

Circumstances in the Dominican Republic

Since the late 1970s, the Dominican Republic has faced a rapidly deteriorating economy. Whereas the 1968-1975 decade produced per capita GDP growth rates approaching 7 percent and foreign exchange earnings grew at over 25 percent during the seven years, the 1977-1984 period saw GDP growth on a per capita basis fall below one percent and export growth slow to less than two percent a year. Projections of GDP growth and foreign exchange earnings between 1985 and 1986 promise further deterioration to negative growth in per capita GDP and exports (Ceara Hatton, 1987). Not surprisingly, the recession has negatively affected government expenditures, and the IMF stand-by agreement has further reduced real government spending, particularly in high recurrent cost areas. For

example, in 1985, the Dominican government allocated DR \$131 million (U.S. \$42.2 million) or 5 percent of the budget to public health services, down from 8 percent in 1982. Thus, although the public health budget has grown modestly in nominal terms between 1981 and 1985, it has fallen by about half in real terms.

The Dominican Republic is an interesting case of a country whose public health sector, while controlled in many respects by the central government, allows considerable facility-specific autonomy in raising revenues from some patients. Thus even though the central government has not specifically acknowledged the effects of declining resources on health care, individual hospitals have been allowed to develop their own responses. Moreover, because the central government attempted to cut its health budget after 1981 by freezing hospital operating budgets at their 1981 levels (Bartlett, undated), hospitals were forced to adjust and cope with fewer budget resources. Some hospital directors have responded by cutting back on services, while others have aggressively pursued additional sources of income. User fees are a popular if not a universal option, although the form and level of fees developed by each facility have been achieved virtually independently of other facilities. The diversity of experience outlined below bears this out.

Government Policy Toward User Fees

The constitution of the Dominican Republic promises "adequate protection against illness," and "free medical assistance and hospitalization to those whose economic resources require it." This pledge has been the foundation for disagreement and controversy over free-services policies in government facilities, and has defined the parameters under which individual hospitals have set fees. Thus government policy stipulates that charges for all inpatient services are prohibited. Policy toward outpatient care is ambiguous, and the lack of guidelines has provided a conducive environment for experimentation by individual hospitals. Controversy continues, however, as to whether all health care must be free to all citizens or whether the government only has a responsibility to some citizens (e.g., those who cannot pay) or for some services.

The unarticulated policy toward outpatient fees in the Dominican Republic, the existence of a 1940s law that implicitly authorizes fees for certain services, and the considerable autonomy of individual public hospitals with regard to hospital-raised resources have led to the development of a diverse set of fee-for-service experiences across the country. Hospital allocations of their centrally allocated budgets are stipulated, but hospitals are not subject to oversight in setting outpatient fees, or handling and expending independently raised revenues. Thus hospital directors have a free hand in raising and spending funds.

The Public Health System

The Secretariat for Public Health and Social Welfare (SESPAS) owns and operates 101 hospitals, health centers and subcenters in seven regions and the national capital area. The 46 public hospitals provide the full range of primary, secondary and tertiary care, although some rural hospitals provide only limited services. Specialty hospitals in Santo Domingo and the regional hospital in Santiago provide specialized diagnostic and treatment services such as dialysis, incubators, and cancer treatment. Hospital operating budgets are allocated and regulated by SESPAS. All services are meant to be free, especially for those who cannot afford to pay. Indeed, central government allocations to hospitals are aimed at allowing facilities to extend free care.

Hospital budgets are in two parts. The first is the personnel budget, and personnel are hired (through competitive examination), assigned and paid by the central government. Since there is no established civil service system, staff composition tends to shift with changes in administration, which has meant every four years over the past decade. Moreover, there is no system of program budgeting so personnel allocations are unsystematic with regard to numbers, type and specialty. In 1984, personnel captured about 68 percent of the total budget, up from 50 percent in 1975 and 58 percent in 1980. The proportion was to have remained constant over subsequent budget periods, but no data

are yet available to verify this. SESPAS ratio of expenditures on materials and supplies to spending on personnel decreased by 36 percent between 1980 and 1983 (Bartlett).

The second part of the budget is the operating funds for all nonpersonnel costs that until very recently was based largely on historical allocations. Newly introduced reforms are meant to establish a systematic budgeting process for health facilities. Any funds over and above the government's budget are raised by the facility either through a group of friends of the facility, the "Patronato" that raises money through outright gifts or charity functions, international donor contributions of materials (e.g., chemical reagents, specialized equipment), or revenue from patients.

SESPAS has a set formula for allocating hospital operating budget expenditures: drugs 50 percent, food 30 percent (to feed both patients and staff), maintenance 5 percent, staff education and professional development 1 percent, and the remainder for other items. Government auditors, while they oversee expenditure of central funds, are not responsible for reviewing the books of internally generated revenues nor are hospitals required to report the sources or amounts of revenue raised. Thus these monies become the source of discretionary expenditures for hospitals.

Data

The facilities in the study include nine regional or specialty hospitals and the Dr. Defillo National Laboratory. The nine hospitals were selected from four of the seven regions and the capital city, with a bias toward facilities in Santo Domingo. Hospitals include regional and general hospitals and three specialty hospitals. The National Laboratory was included because of its extensive and successful experience with user fees. Chronic care facilities are not included.

Data were collected from each individual hospital through the examination of accounting and patient records, and discussions with hospital directors, administrators and social workers. Data quality is very high, although not as complete as desirable due to

irregular bookkeeping and recent changes in key personnel due to the change in administration in 1986.

The facilities included in the sample and some salient characteristics for each are presented in Table 1. The largest hospital is Jose Maria Cabral y Baez in Santiago, the Dominican Republic's second largest city. The hospital provides a broad range of services both general and specialized and is a unique institution in the Dominican Republic. The other regional hospitals are of varying sizes but each represents the main facility in that region. The number of inpatients and outpatients per facility varies widely: the ratio of inpatients to outpatients ranges from about 7 to 24 (Maternidad Hospital), with the lower ratios generally more common in the specialized hospitals in Santo Domingo, where lengths of stay may be longer and hence these hospitals have a smaller number of inpatients. If this is the case then it suggests the system is operating as planned with specialized care providing more intensive care and regional hospitals providing more general care. Unfortunately, data regarding average lengths of stay or occupancy rates, that might shed light on costs and utilization across hospitals, are not available. These kinds of measures, along with case mix data, would allow a more meaningful comparison across facilities.

User Fees in Hospitals

Outpatient Services. Because there has never been any clear policy from the central government on outpatient charges at public hospitals, fees have evolved in an ad hoc fashion in response to perceived needs and the initiative of hospital directors. All of the ten facilities in the sample have some fees for outpatients. A number of hospitals refer to fees as "donations" to indicate the optional nature of the charges.

What services have charges and the amounts charged by each facility vary widely. Table 2 summarizes the fee schedules for the ten facilities, with only selected services shown. Only a few of the facilities have published fee schedules that indicate charges on a service-specific basis. The National Laboratory and Cabral y Baez Hospital have the most

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TABLE 1
Summary Characteristics of Public Facilities in the Sample

Facility	Type of Facility	Location	No. of Beds (1986)	No. of Inpatients (1986)	No. of Outpatients (1986)
Carl George	Region V Hospital	San Pedro de Macoris	48	4,926	21,700
Dr. Dario Contreras	Trauma Hospital	Santo Domingo	233	4,014	49,465
Jaime Mota	Region IV Hospital	Barbados	90	4,673	32,117
Jose Maria Cabral y Baez	Region II Hospital	Santiago	414	21,099	119,700
Juan Pablo Pina	Region I Hospital	San Cristobal	234	10,706	70,947
Maternidad, Nuestra Senora de la Altagracia	Maternity Hospital	Santo Domingo	252	19,224	79,232
Dr. Luis E. Aybar	General Hospital	Santo Domingo	225	5,045	69,383
National Laboratory Dr. Defillo	National Laboratory	Santo Domingo	N/A	n.a.	n.a.
Dr. Padre Billini	General Hospital	Santo Domingo	148	2,981	40,257
Robert Reid Cabral	Children's Hospital	Santo Domingo	268	7,632	112,143

Source: SESPAS Statistics

Note: n.a. means data are not available.

TABLE 2

Outpatient Fee Schedule for Selected Services at Ten Hospitals, 1986
(Dominican Pesos)

	Laboratory					X-Ray ^a		Electro- cardio- gram	Consul- tation
	Min. Fee	Max. Fee	Pap Smear	Blood Typing	Hemo- gram	Min.	Max.		
Carl George ^b	5.00	5.00	N/A	2.00	2.00	8.00	16.00	N/A	none
Dr. Dario Contreras	1.50	10.00	N/A	1.50	1.50	5.00	20.00 ^c	N/A	0.50
Jamie Mota	0.05	3.00	5.00	3.00	3.00	6.00	6.00	N/A	none
Jose Maria Cabral y Baez	5.00	^d	1.00	5.00	5.00	10.00	40.00 ^e	2.00	0.50 ^f
Juan Pablo Pina	0.50	5.00	10.00	0.50	1.00	20.00	20.00	10.00	0.25
N.S. de la Altagracia	1.00 ^g	40.00	3.00	2.50	2.00	30.00	60.00 ^e	N/A	0.30 0.10 ^h
Dr. Luis E. Aybar	1.00	5.00	N/A	3.00	3.00	10.00	75.00	N/A	none
National Laboratory	3.00	35.00 ⁱ	6.00	6.00	5.00	N/A		N/A	none
Dr. Padre Billini	2.00	12.00	5.00	n.a.	n.a.	10.00	45.00	5.00	0.50
Robert Reid Cabral	1.00	1.00	N/A	1.00	1.00	5.00	40.00 ⁱ	10.00	0.25 ^k

- a. Price is per x-ray film taken unless otherwise indicated.
- b. Pregnant women, children, and students are not charged.
- c. X-ray services range from a picture of a child's thorax (DR\$ 5.00) to simple abdominals (DR\$ 20.00).
- d. Routine tests such as tests for creatinism and hemoglobin levels are charged the minimum price. Sophisticated tests are not included in the price list. All tests have fees attached.
- e. The higher cost is for sonograms and other sophisticated services.
- f. Charge inpatients and outpatients for record card on first visit.
- g. For a first outpatient visit, a set of five tests are provided for a flat fee of DR\$ 5.00. Tests include a pap smear, blood typing, urine, blood, and STD test.
- h. For the first pediatric visit.
- i. Upper range covers glucose tolerance tests and hormonal radioimmuno assays.
- j. X-ray charges vary according to ability to pay and are assessed by the nun in charge of the x-ray department. Roughly 50% of patients pay the minimum, DR\$ 5.00 per x-ray. Maximum payment for a full set of x-rays is DR\$ 40.00.
- k. Charge for receptacle for received medication.

Note: N/A indicates no applicable.
n.a. indicates data are not available.

Exchange rate 8/87 US\$ 1.00 = DR\$ 3.70

extensive and complete fee systems. Juan Pablo Pina, Dario Contreras and Maternidad Hospitals have fee schedules but include only some services; however, this is not surprising in Contreras Hospital, the trauma center, and the maternity hospital that only treat certain problems. The others have charges for some select services but their fee systems are less comprehensive.

Outpatient fees are based on some combination of a fraction of private sector prices, average costs of supplies, and the perceived ability and willingness of patients to pay. Fees rarely exceed 10 percent of private sector prices for similar services, and frequently are far less. The Cabral y Baez Hospital sets charges according to cost estimates of the chief medical officer in each department or 10 percent of private prices, and their prices are on average higher than those at other hospitals, which suggests that fees are well below market. The National Laboratory uses rough estimates of the cost of personnel, equipment, and supplies to determine prices. Most facilities, however, set charges that cover the average marginal cost of supplies (e.g., x-ray film, chemical reagents and EKG paper), since government allocations are insufficient to cover these expenses. Indeed Robert Reid Cabral Hospital estimates that the Government budget allocation only covers one quarter of x-ray supply costs. Issues of cross-subsidization or utilization incentives, while they occur by default, have not typically been seen as a basis for fee setting.

Some hospitals charge per test others have a flat fee for all laboratory (Carl George Hospital) or x-ray (Jaime Mota Hospital) services regardless of how many or how complex these tests are. Contreras Hospital will charge per x-ray for simple services and charges a flat fee for a series of more complicated x-rays. The National Laboratory and Cabral y Baez Hospital charge separately for each service. Expensive procedures and drugs are borne by the hospital whenever possible, but typically patients are asked to contribute toward the cost as well.

About half of the facilities in the sample levy a consultation fee. All facilities charge for laboratory services, but as can be seen in the table, the differences in the range and the price of specific services are considerable across facilities. Some hospitals have a flat fee for laboratory work, such as Hospital Carl George, and others like Hospital Jose Maria Cabral y Baez have no upper limit since prices are a function of average costs. X-rays typically have charges attached to them as well, and the differences are striking here too. Some of the differences in the maximum x-ray price reflect availability of more sophisticated and costly services such as sonograms that are only available at a few Dominican hospitals.

Inpatient Services. Inpatient services, in accordance with constitutional interpretation, generally do not have fees attached to them. There are a few exceptions. Some hospitals send patients to other facilities for tests (for example to the National Laboratory), and patients are required to pay any associated fees there. Cabral y Baez Hospital charges DR\$.50 for a record card. Aybar Hospital has a nominal charge of DR\$ 25.00 for eye bank surgery because of the specialized nature of the service. Contreras Hospital charges for physical therapy starting at DR\$ 1.00 per session. Otherwise, hospitalization is free.

Cabral y Baez Hospital has a private wing of 24 beds where patients receive improved hotel and additional nursing services at prices below the private sector charges. Patient services are recorded on their charts and charges are imposed for all goods and services. A 20 percent fee is added to the total to compensate the hospital for the enhanced services, and the attending physician charges the patient separately. Separate accounting methods for private patients have led to minimum abuse of the system, although the net earnings to the hospital from private inpatients have never been assessed.

The only other charges associated with inpatient care at some hospitals are for blood. Because the government has no blood bank facilities, each individual hospital handles its own blood needs. Most require patients to obtain and present an appropriate donor where elective surgery is contemplated, and to arrange replacement for blood used in emergency

situations. Juan Pablo Pina Hospital requires that all surgery patients deposit 500 cc's of their blood type plus DR\$ 50.00; Contreras Hospital charges DR\$ 20.00 for a half pint and DR\$ 35.00 for a full pint of blood. In the past, Robert Reid Cabral charged for blood: DR\$ 35.00 for rhesus positive and DR\$ 50.00 for rhesus negative blood. Emergency patients who receive blood are expected to have a relative or friend replace the blood. Thus the hospitals are forced to either have patients bring their own blood supplies or charge them to have the hospital acquire it, and hospitals have used various criteria in setting prices for blood, but their charges are remarkably uniform, reflecting the fact that fees are a function of cost.

What is interesting about the different fee structures and the revenues derived from them is that an understanding of the need for additional resources and concerted efforts to share the cost burden translates into more efficient fee systems. The facilities that charge something for every service offered generally charge slightly more than other facilities for the same service. Thus these facilities spread the burden more widely and price services to better reflect costs.

If user fees are to discourage over-utilization and reflect the true resource costs of the services provided, charges should be imposed on all curative services and should be linked to the costs of providing services. Hence the price of inpatient care should exceed that of outpatient services, and more costly diagnoses and treatments should involve a higher fee. A counterweight to these efficiency criteria are the political ramifications associated with fees and their levels, and the costs and difficulty of administration. In the fee structures described here the latter criteria predominate. Only Cabral y Baez Hospital and the National Laboratory attempt to set fees according to hospital costs (and the fee levels at Padre Billini suggest a similar strategy in past years). Thus while the system as a whole attempts to raise revenues, most hospital directors believe they cannot do so in an efficient manner.

The cost of collection is not seen as a big problem, although hospitals have seen some increase in emergency outpatient demand after cashier hours and are considering extending cashier and social worker hours to cover off-hours. This of course would raise the cost of collection, and would have to be balanced against revenue increases overall once the expanded hours were operational to assess the financial soundness of the proposal. In Sudan, Bekele and Lewis (1986) found that user fee collection costs ranged between 5 and 7 percent of gross earnings, which is not inconsistent with the perceptions of hospital directors in the Dominican Republic. Thus although there are no data in the Dominican Republic, the cost of collection for outpatient services does not appear to be an impediment.

The first major impediment to more rational charges is the inability to charge for the high cost of hospitalization. Inpatients require a much broader set of services, which outpatients do not, such as physician monitoring, and nursing, housekeeping, laundry and food services. Thus outpatients are subsidizing inpatients. Second, outpatients are expected to pay for tests which are free to inpatients, which provides a strong incentive for patients to seek admission to the hospital for laboratory tests or x-rays. Similarly, inpatient consultations are free but outpatients pay a fee to see a physician at some hospitals. Lastly, outpatients are much more likely to be seeking preventive services (e.g., pap smears or pre-natal care) than are inpatients. If government perceives that preventive services are merit goods and therefore can justify subsidies to these services to increase their use above what they would be otherwise (Roth, 1987; deFerranti, 1985), the subsidy component should be larger than that of curative care where demand is high and the benefit to the individual exceeds society's benefits.

Thus although fees are in place, their structure in all facilities provide the wrong incentives for consumers. Subsidies promote inpatient over outpatient care and are greater for curative than for some preventive care. More revenue could be raised by charging inpatients, especially at specialty hospitals where inpatients often can pay, but more

importantly, fees would then better reflect resource use. This is not to say that existing outpatient fees should be abolished, but that hospitalization should not and need not be free for everyone.

Sources of Medical Facility Resources

Government operating budgets for most hospitals have remained largely stagnant for the last few years, in keeping with SESPAS's decision to freeze hospitals' annual allocations. This has occurred during a period of high inflation (130 percent between 1980 and 1985) recession, and relatively high population growth of 2.5 percent annually between 1980 and 1985 (Ramirez, Duarte, Gomez, 1986). The incentives for hospital directors to seek funds elsewhere or expand their debt (by simply not paying bills) to cover operating costs have therefore been very strong since 1980. Indeed, hospital financing is currently achieved through government transfers, mounting hospital debt, and facility revenues, supplemented in some instances by the aforementioned "Patronatos" and other donor and charitable contributions.

The two budgets, for personnel and operating costs, hospital debt and the outpatient revenues of the ten facilities are shown for 1986 in Table 3. The relationship between the personnel and operating budgets is random, ranging from 16 at Jaime Mota Hospital to 76 at Contreras Hospital. The others tend to concentrate around 20 to 30.

Cabral y Baez Hospital has the largest staff, the biggest budget, the highest debt, and the most revenues. The National Laboratory's outpatient revenues are almost twice its operating budget, while Jaime Mota, Robert Reid Cabral and Aybær Hospitals have only raised 3, 3 and 4 percent respectively of their operating budgets. Padre Billini Hospital raised about 17 percent of its budget in 1986. The rest hover around 10-12 percent for 1986. The effectiveness of fees in proportion to operating budgets at Contreras, Padre Billini, and Cabral y Baez Hospitals and the National Laboratory are evident. The fees described in Table 2 (as well as fees charged for services not listed in the table) reflect these

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TABLE 3
Facility Personnel and Operating Budgets,
Debt Burden and Outpatient Revenues for Selected Facilities, 1986
(Dominican Pesos)

	Personnel Budget	Operating Budget	Hospital Debt	Outpatient Revenues ^a	Average Outpatient Revenue
Carl George	831,054	180,000	88,784	27,914	1.29
Dr. Dario Contreras	1,261,548	960,000	326,342	178,163	3.60
Jaime Mota	785,450	126,000	n.a.	6,420	0.20
Jose Maria Cabral y Baez	6,174,230	2,190,000	792,271	257,118	2.15
Juan Pablo Pina	1,782,168	540,000	50,823	59,290	0.84
Maternidad, Nuestra Senora de la Altagracia	2,551,612	840,000	177,238	85,400	1.08
Dr. Luis E. Aybar	1,739,038	900,000	254,253	35,443	0.51
National Laboratory	n.a.	132,000	13,427	238,660	n.a.
Dr. Padre Billini	n.a.	315,000	n.a. ^b	52,495	1.30
Robert Reid Cabral	1,967,350	840,000	0	24,121	0.22

- a. Excludes donor and charitable contributions as well as the donations of the "Patronato" where these apply. Includes Jose Maria Cabral y Baez Hospital's inpatient receipts.
- b. Since the recent change in administration previous records cannot be located, however, according to the previous director of Robert Reid Cabral Hospital, Dr. Hugo Mendoza, Dr. Padre Billini Hospital was the only other debt-free public hospital in 1986.

facilities' commitment to cost sharing with users. The prices at these facilities are slightly higher than average for comparable services, and they charge for each service even if the fee is modest (e.g., consultation fees). The last column of Table 3 suggests the consistency of collection across patients (implicitly assuming equal ability to pay) for these four facilities. Fees in Jaime Mota and Robert Reid Cabral Hospitals, on the other hand, are almost incidental; charges are far below those of other public hospitals.

Deficit finance to cover operating costs became increasingly popular in public hospitals over the last half decade in response to insufficient resources and services (e.g., SESPAS equipment maintenance). Debt as a percent of the operating budget, technically the source of funds to pay off debts, is as high as 50 percent (Carl George Hospital) although most hospitals are closer to 30 percent of their operating budgets. As of 1986 only Robert Reid Cabral Hospital (and reportedly Dr. Padre Billini) are debt free. The National Laboratory and Juan Pablo Pina Hospital have a modest debt of roughly 10 percent of their SESPAS operating budgets.

Debt may also be an implicit source of low (or zero) interest loans, since the National Laboratory has expanded its facility, raised significant amounts of funds and yet maintains a modest debt balance. Deficit finance may also be an artifact of the sharp drop in SESPAS' materials and supplies allocations over the past few years, and therefore is a transitional financing mechanism. But given budget projections, the transition will have to be to greater reliance on user contributions or charity, because there is a limit to the amount of debt that can be accumulated since providers will terminate their services to non-paying hospitals.

How important discretionary funds are in hospitals' overall resource base puts the absolute earnings in perspective, and also suggests what level of cost recovery is possible in public hospitals. Table 4 provides the sources of operating funds (personnel costs are excluded) in 1986 by percent for the ten facilities in the sample. Excluding the National Laboratory, hospitals receive the bulk of their funding from SESPAS. Outpatient fees are

TABLE 4
Sources of Funds for Selected Facilities, 1986
(Percent)

Facility	Operating Budget	Donors	Patronato	Outpatients			Inpatients	Other
				Lab	X-ray	Total ^a		
Carl George	80.5	0	7.0 ^b	9.1	2.1	12.5	0	0
Dr. Dario Contreras	83.8	0	0	1.0	13.0	15.6	0.6	0
Jaime Mota	95.2	0	0	4.8	0.0	4.8	0	0
Jose Maria Cabral y Bae	69.9	0	0	1.9	3.4	8.2	12.1	9.8 ^c
Juan Pablo Pina	89.4	0.8	0	NA	NA	9.8	0	0
Maternidad. Nuestra Senora de la Altagracia	79.3	2.4 ^d	8.1 ^e	3.9	0.0	8.1	0	2.1 ^f
Dr. Luis E. Aybar	94.0	0.4 ^g	0	NA	NA	3.7	1.9 ^h	0
National Laboratory	34.2	3.9 ⁱ	0	61.9	0.0	61.9	0	0
Dr. Padre Billini	85.3	0 ^j	0	0.0	3.6	14.2	0	0.5 ^k
Robert Reid Cabral	73.3	12.6	12.0	0.6	0.4	2.1	0	0

- a. The total also includes consultation fees, special charges, health cards and other payments; hence the percents do not add up to the outpatient percent total.
- b. Donation from Central University of the East
- c. 91.3% of the total represents a gift from Juegos Santiago, the 1986 Pan American Games
- d. Gift from JHPIEGO/UNICEF
- e. 83.6% is the value of in-kind donations of equipment, drugs and maintenance service.
- f. 63.3% was received from the Association Ganaderas
- g. Donation from International Eye Foundation.
- h. 81.6% from endoscopic surgery fees.
- i. Books and equipment donated by PAHO.
- j. Donations have been received from various sources but neither the donor nor the amount or value are recorded.
- k. Value of housing services donated to the hospital.

the single largest non-budget source of funds for all but Robert Reid Cabral Hospital. Inpatient fees are significant only for Jose Maria Cabral y Baez Hospital, which has a functioning private wing. Robert Reid Cabral and Maternidad Nuestra Sra. de la Altagracia Hospitals have active "Patronato" efforts that have raised considerable amounts, which exceed and equal, respectively, the proportion that fees contribute to resources in these facilities. A number of the hospitals also have volunteer groups within the hospital that raise money, assist needy patients, and generally contribute to the overall functioning of the hospital. No estimates were obtainable regarding the value of these services.

Consultation fees probably bring in the largest amount of revenue, based on the difference between x-ray and laboratory, and total outpatient revenue. Although the fee is modest, the volume of patients ensures a considerable amount of revenue from consultation fees. Both laboratory and x-ray services have considerable revenue potential, and the results in the table are a combination of how much is charged, how frequently services are needed (eg. Contreras hospital uses x-rays intensively for accident victims), and the overall patient load of the facility.

Trends in Medical Facility Resources

In most instances, fee revenue is rising rapidly. The trends in outpatients, outpatient revenues, government budgets and debt are shown in Table 5. Although data on shifts in fees overtime are not available, the trends in the table for the 1984-1986 period (and the 1982-1986 period for Juan Pablo Pina and Robert Reid Cabral Hospitals) suggest that, in nominal terms, charges have either increased, fees are being added to new services at most facilities or hospitals are collecting revenues more consistently.

About 60 percent of the sampled hospitals are losing outpatients, budgets are generally stagnant in nominal terms and falling in real terms (Robert Reid Cabral and the Cabral y Baez Hospitals are the exception), and output revenues are rising sharply and typically outpacing inflation. Only Jaime Mota is experiencing a modest downturn in

1500

TABLE 5
Growth in Outpatients, Operating Budgets, and Debts
for Selected Facilities, 1984-1986

Hospital ^a	Percent Change in Number of Outpatients	Percent Change in Government Budget	Percent Change in Debt	Percent Change in Outpatient Revenues
Carl George	12.2%	0.0%	15.5%	21.4%
Dr. Dario Contreras	-12.4	0.0	2611.5	6.3
Jamie Mota	-13.5	0.0	0.0	-1.3
Jose Maria Cabral y Baez	-14.7	18.1	2.8	103.4
Juan Pablo Pina ^b	-14.2	12.5	-32.3	29.7
N.S. de la Altagracia	-14.2	0.0	-13.3	24.8
Dr. Luis E. Aybar	13.3	12.5	31.4	185.8
National Laboratory	n.a ^c	0.0	36.8	6.7
Robert Reid Cabral ^b	17.2	27.3	-100.0	90.6

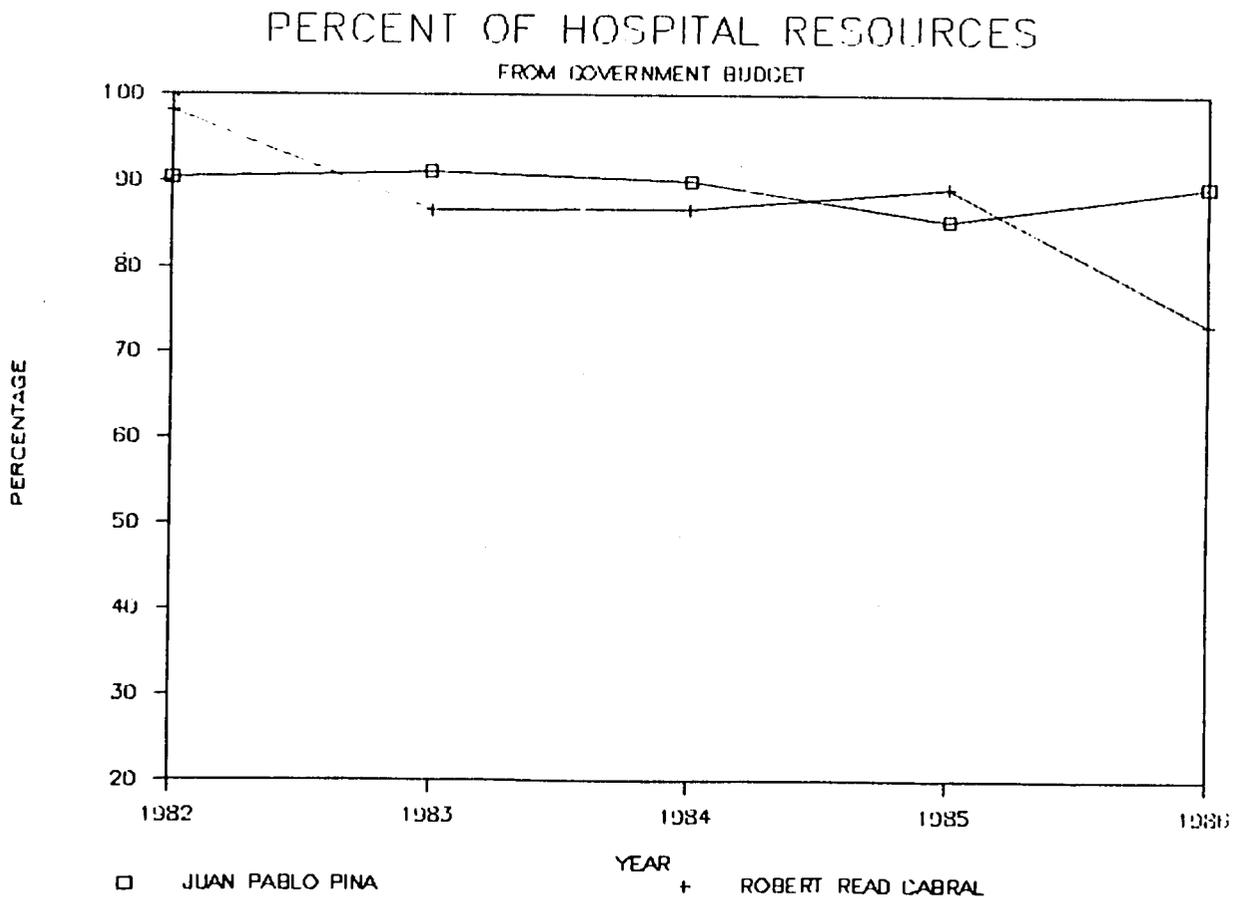
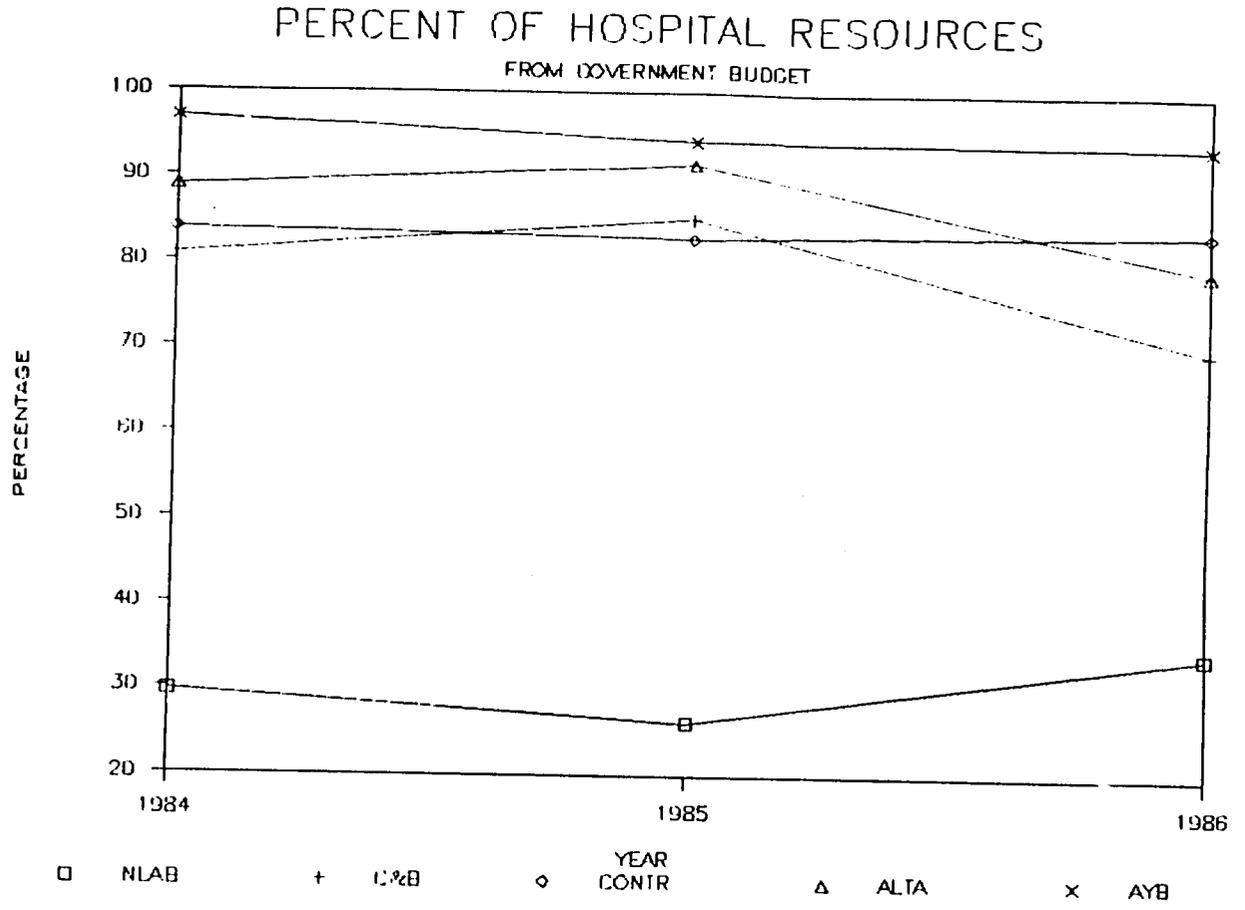
- a. Trend data not available for Dr. Padre Billini Hospital.
- b. Changes are between 1982 and 1986.
- c. Although outpatient data are not available for the National Laboratory, the annual number of tests performed has risen consistently over the past five years.

nominal revenues, but it is located in one of the poorest areas and has a limited commitment to fees as a means of raising additional resources. Additionally, its x-ray machine has been dysfunctional for two years, which limits its ability to charge for these outpatient services. In real terms, however, the National Laboratory, Contreras Hospital, and Juan Pablo Pina Hospital have experienced a reduction in annual revenues because growth in earnings has lagged behind inflation. The results are not surprising for Juan Pablo Pina Hospital since data cover the period 1982-1986, during which time consumer prices almost doubled.

Reduced utilization is largely attributed to deteriorations in quality that have discouraged patients, according to hospital directors and other observers. Lack of drugs, broken machinery and lack of supplies have limited the extent and quality of out- and inpatient services. In 1985 a PAHO-supported study of public hospitals found that 90% of incubators, three quarters of x-ray and laboratory equipment, and almost half of the sterilizers were nonfunctional (SESPAS/PAHO, 1985).

Since fees are rising, in theory they might discourage use; however, fees have typically received minor increases and all patients have the opportunity to have charges waived (see section on Means Testing). According to hospital social workers, fee increases have generally not resulted in increases in patient requests for waivers. They too attribute patient declines to deteriorations in quality. Further crude evidence is the fact that Aybar Hospital, with the highest fee increases between 1984 and 1986, also had one of the largest rises in outpatients during the period.

The growth in fee revenues is shifting hospital dependence away from government budget allocations. The two graphs in Figure 1 show the proportion of hospital resources attributable to government transfers between 1984-1986 and 1982-1986. Only the National Laboratory has shown a rise in the proportion of resources from SESPAS, although it is the facility least dependent on central government resources. Indeed the rise for the National Laboratory is really an artifact of the sharp drop in donor funds as the Laboratory's research on schistosomiasis ended.



Reduced dependence on the government is due both to the limited growth in government monies over the past few years and to the increasingly successful efforts to raise funds through fees and charitable contributions. Figure 2 shows how outpatient revenues have grown in the 1984-1986 period, and indicates how the levels vary across facilities. During this relatively short period, earnings have grown most dramatically for Jose Maria Cabral y Baez Hospital whose absolute earnings were already relatively high, and have grown to well above any of the other facilities aside from the National Laboratory.

How much facilities receive relative to their patient load is important in assessing how successful they have been in raising revenue. If very little revenue is raised per patient the system is not particularly effective nor is a serious effort being made to supplement the budget. Table 6 provides detail on how much facilities have raised relative to outpatient volume, and how much they received in operating budget support per outpatient during the years 1984 to 1986. The reduction in the number of outpatients between 1984 and 1986 prevents a decline in the amount of operating budget hospitals receive per outpatient, although the reduction in real terms reduces the value of the budget transfer by about 30 percent between 1984 and 1986. Only Aybar and Carl George Hospitals lost budget on a per capita basis (despite a 12.5 percent boost in Aybar Hospital's SESPAS budget) because outpatients increased by 13.3 and 12.2 percent during that period at Aybar and Carl George Hospitals, respectively (See Table 5).

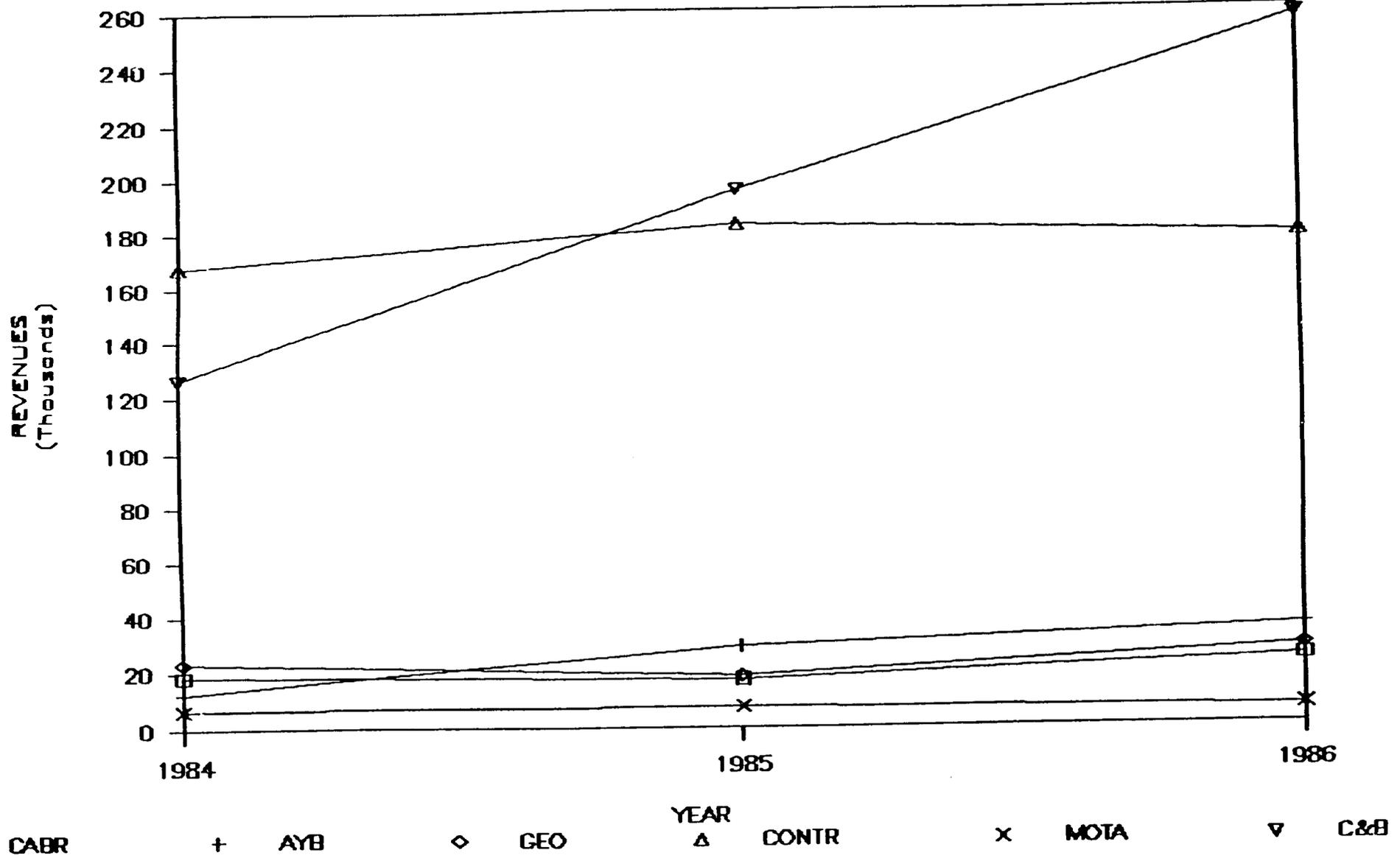
Revenues per outpatient also rose during the period, at least in nominal terms, and in percentage terms improved at a faster rate than per capita budget levels. Aybar Hospital had the biggest increase in per capita revenues, having increased by 155 percent, although from a modest base. Cabral y Baez Hospital's per capita revenues rose by 139 percent, which means that in real terms they improved by over 100 percent.

Contreras. Cabral y Baez and Aybar Hospital receive the largest operating budgets from SESPAS per outpatient (and per inpatient). The first two also generate the largest

FIGURE 2

LEVEL OF OUTPATIENT REVENUES

OVER TIME



amount of revenue on a per capita basis, suggesting that the operating costs of these hospitals is higher on average than those of the other facilities. Given the sophistication of all three facilities and their position as the highest level of care, the discrepancies are just a reflection of their case mix. For example, Contreras Hospital handles all trauma cases as well as follow up care, and these services are costly; Aybar Hospital performs cornea transplants and other high technology eye care.

Rising costs and modest or no budget increases appear to be making facilities more cognizant of the need to raise funds from patients who can pay. The longitudinal experience indicated in Table 6 suggests the relative commitment of hospitals in sharing costs with users as a means of meeting costs other than through debt.

The data presented in this section suggest that user fees are an important source of funding for public hospitals and that hospitals could raise additional funds through a more aggressive stance, since some facilities are so much more successful than others at raising funds.

The more successful fee systems in the Dominican Republic from the point of view of per outpatient revenues, debt history and trends in revenue levels are characterized by: 1) fees that reflect resource use wherever possible; 2) fees are assessed for most if not all services, even if they are only token charges; 3) high volume services incur charges. These principles conform to the theoretical constructs that charges should be a function of costs, and charging something is better than nothing since resources are being used and are not infinite.

The hospitals that have made a commitment to cover some portion of costs through raising funds from patients who can pay have raised a good deal of money, covering as much as 31% of hospital operating costs, and 66% of the National Laboratory costs. A hospital like Aybar has managed to obtain an increase in its SESPAS operating budget and is expanding its debt. Contreras Hospital, because its costs are so high, has sought multiple

182

TABLE 6

Government Budget and Fee Revenues in Relation to
Outpatient Volume, 1984-1986
(Pesos)

	1984		1985		1986	
	Revenues/ Outpatients	Operating Budget/ Outpatients	Revenues/ Outpatients	Operating Budget/ Outpatients	Revenues/ Outpatients	Operating Budget/ Outpatient
Carl George	.82	6.45	.78	7.71	1.29	5.75
Dr. Dario Contreras	2.97	17.00	3.88	20.39	3.60	19.41
Jaime Mota	.25	4.90	.31	5.33	.20	5.66
Jose Maria Cabral y Baez	.90	13.22	1.72	16.63	2.15	18.30
Juan Pablo Pina	.65	5.85	.85	6.96	.84	6.02
N.S. de la Altagracia	.75	9.10	.71	10.83	1.08	10.60
Dr. Luis E. Aybar	.20	13.06	.47	14.78	.51	12.97
Robert Reid Cabral	.19	6.90	.17	8.26	.22	7.49

sources of funds, from dramatic increases in debt to higher fees and more aggressive collection. The National Laboratory and Cabral y Baez Hospitals appear committed to raising revenues from users; however, the National Laboratory is a special case in that it is exclusively an outpatient facility and can easily charge for its services. Its experience suggests that raising laboratory charges in other hospitals could increase revenues, and the experience at the Cabral y Baez Hospital reinforces this conclusion.

Robert Reid Cabral Hospital, a pediatric hospital, has successfully raised resources from its "Patronato," an option that is probably not as attractive to hospitals with a more general mission, but not out of the question. The experience of Carl George Hospital, with 7% of its income from its "Patronato", being a case in point. Jaime Mota Hospital, with a tiny operating budget and very modest outpatient revenues, must have been forced to sacrifice quality, since the pattern in other facilities has been to find some means of covering rising costs while budgets experience minimal if any increases.

Thus fees appear to be the marginal additional resource that keeps hospitals operating. These resources allow the purchase of basic inputs to medical care, without which the labor component (eg., physicians and nurses) could neither function nor be effective. The alternatives to fees are rising debt, fewer patients, or lower quality. And although user fees typically do not entirely substitute for these alternatives they mitigate their effects. Fees are clearly crucial to some hospitals' continued operation and are key to maintaining quantity and quality of services.

Expenditure of Revenues

Expenditures of discretionary resources are determined by the hospital director and occasionally by department heads. Allocations of funds are unregulated and are earmarked for essential but under-financed goods and services. Table 7 provides data for nine of the ten facilities, including information on total expenditures of discretionary revenues in 1986 and the distribution of those monies across expenditure categories. Where possible, the

19

TABLE 7

Expenditures of Discretionary Revenues for Selected Hospitals, 1986

Hospitals ^a	Total (Pesos)	% to Drugs	% to Personnel	% to Maint.	% to Equip.	% to Supplies	% to Food	% to Other
Carl George	36,221.56	55.9	0.1	15.2	3.5	0.0	5.9	19.4
Dr. Dario Contreras	181,256.62	29.8	4.1	8.1	0.0	25.7	30.9	1.6
Jaime Mota	6,118.19	81.5	5.7	3.5	1.8	0.0	4.9	2.4
Jose Maria Cabral y Baez	244,395.63	13.4	--	37.3	--	29.7	8.3	11.4
Juan Pablo Pina	48,665.54	53.2	24.3	8.8	2.1	0.0	0.7	10.8
Maternidad, Nuestra Senora de la Altagracia	119,770.04	11.5	14.0	34.1	9.3	18.7	5.2	7.1
Dr. Luis E. Aybar	28,306.05	19.4	2.4 ^b	8.2	0.0	0.0	0.7	69.3 ^c
National Laboratory	488,916.05	0.0	23.8	2.5	1.1	69.7 ^d	0.0	2.9 ^e
Robert Reid Cabral	25,042.63	8.9	57.1 ^f	2.7	0.0	13.6	12.1	5.6

- a. Data not available for Dr. Padre Billini Hospital.
- b. All for clerical services.
- c. 87.7% is allocated to the gastroenterology department.
- d. 79.9% for purchase of reagents.
- e. 80.7% to construction.
- f. All allocated to administrative and unskilled workers.

value of donated time and materials are imputed and included in the total. A more aggregated picture of allocations is shown in Figure 3 for the same nine facilities.

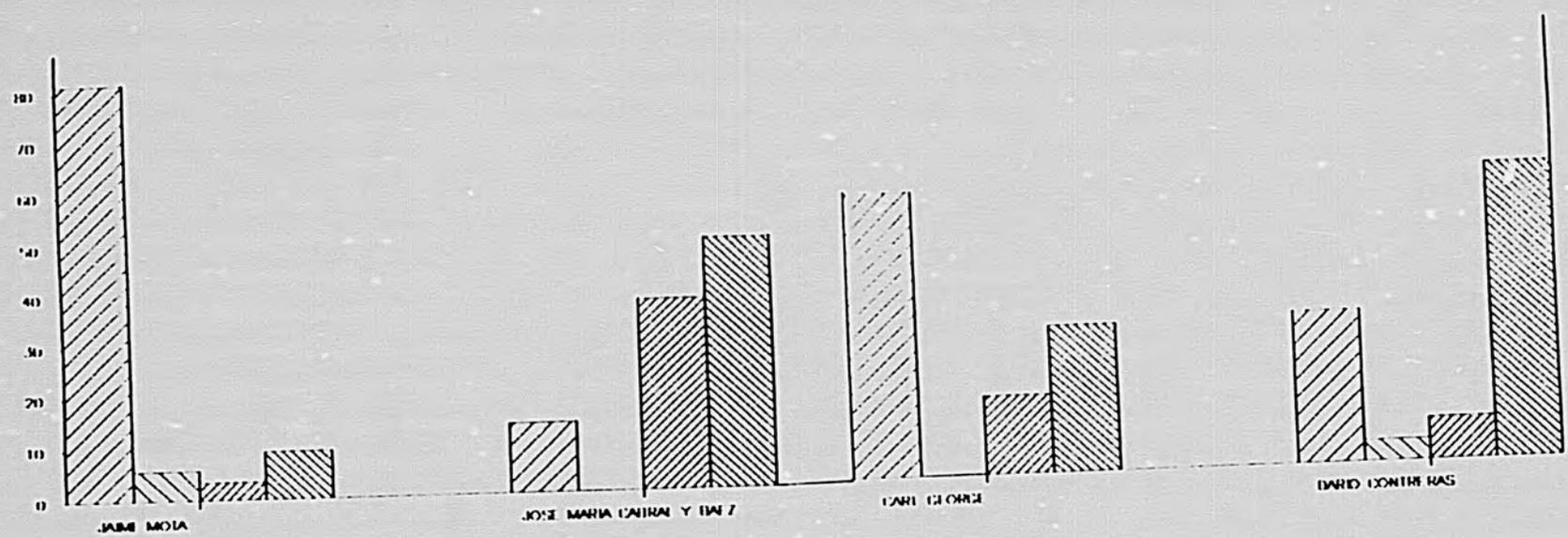
In 1986, drugs were the most frequently purchased item; only the National Laboratory does not buy pharmaceuticals. These purchases supplement SESPAS's allocation and cover the cost of costly drugs not provided through PROMESE. Personnel is a priority for a number of facilities, while others believe that personnel, especially technical personnel, is an unacceptable expenditure category for hospital revenues. Government policy is vague on this point, and a number of hospitals have selected to pay for additional technical and unskilled staff. Some of the expenditure is to top salaries to attract and keep better technical staff.

The National Laboratory tops technician's salaries, pays overtime, and hires additional staff. Sixty percent of its 1986 allocation to personnel paid salaries of laboratory technicians, and 40 percent paid unskilled workers' salaries for gardening, cleaning, and other menial tasks. Robert Reid Cabral Hospital, with the largest percentage going to personnel, allocates funds to administrative and unskilled workers exclusively; however, the hospital's "Patronato" has in the past paid the salary of physician specialists to supplement the hospital physician staff. N.S. de la Altagracia has had a similar arrangement to compensate for skill gaps on its staff. Hospitals complain about excessive numbers of physicians and inappropriate staff mixes, and these discretionary resources compensate for the central government's staff allocations over which hospitals have minimal control.

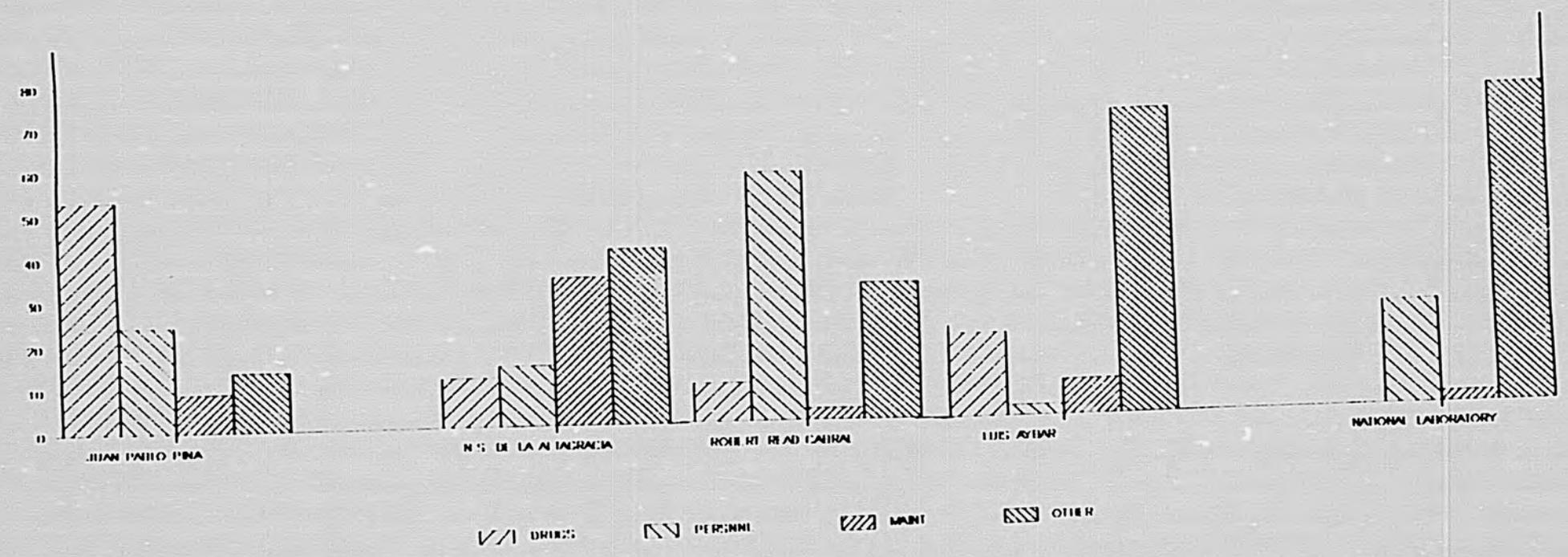
Most facilities spend something on maintenance, but surprisingly equipment is not rarely purchased. Additional food expenditures are required in a number of facilities despite the heavy allocation from the SESPAS budget, largely due to the requirement that the staff be served as well as patients. Supplies are either quite important or facilities spend nothing on them at all. Anecdotal evidence suggests that patients must bring supplies with them. The proliferation of x-ray services, pharmacies and other medical supply purveyors in close

PERCENT ALLOCATION OF RESOURCES

PERCENTAGE



PERCENTAGE



200

DIRECT
 PERSONNEL
 MAINT
 OTHER

proximity to public hospitals and the aforementioned study identifying the staggering percent of non-functioning equipment, lends some credence to the story, but real evidence is lacking.

The "other" category receives a substantial proportion of discretionary resources, but with few exceptions the purchases are obscure. Part of the problem in identifying expenditures are the facilities' record-keeping systems, which lump a wide variety of purchases together with little or no explanation. Only Aybar Hospital allocates a significant chunk of its earnings to a single department: over 69 percent of its discretionary funds goes to the gastroenterology department.

The level and pattern of expenditures varies over time. Figures 4 and 5 indicates shift in expenditure patterns for the seven facilities for the 1984-1986 period, and the pattern for two hospitals for which there are data beginning in 1982.

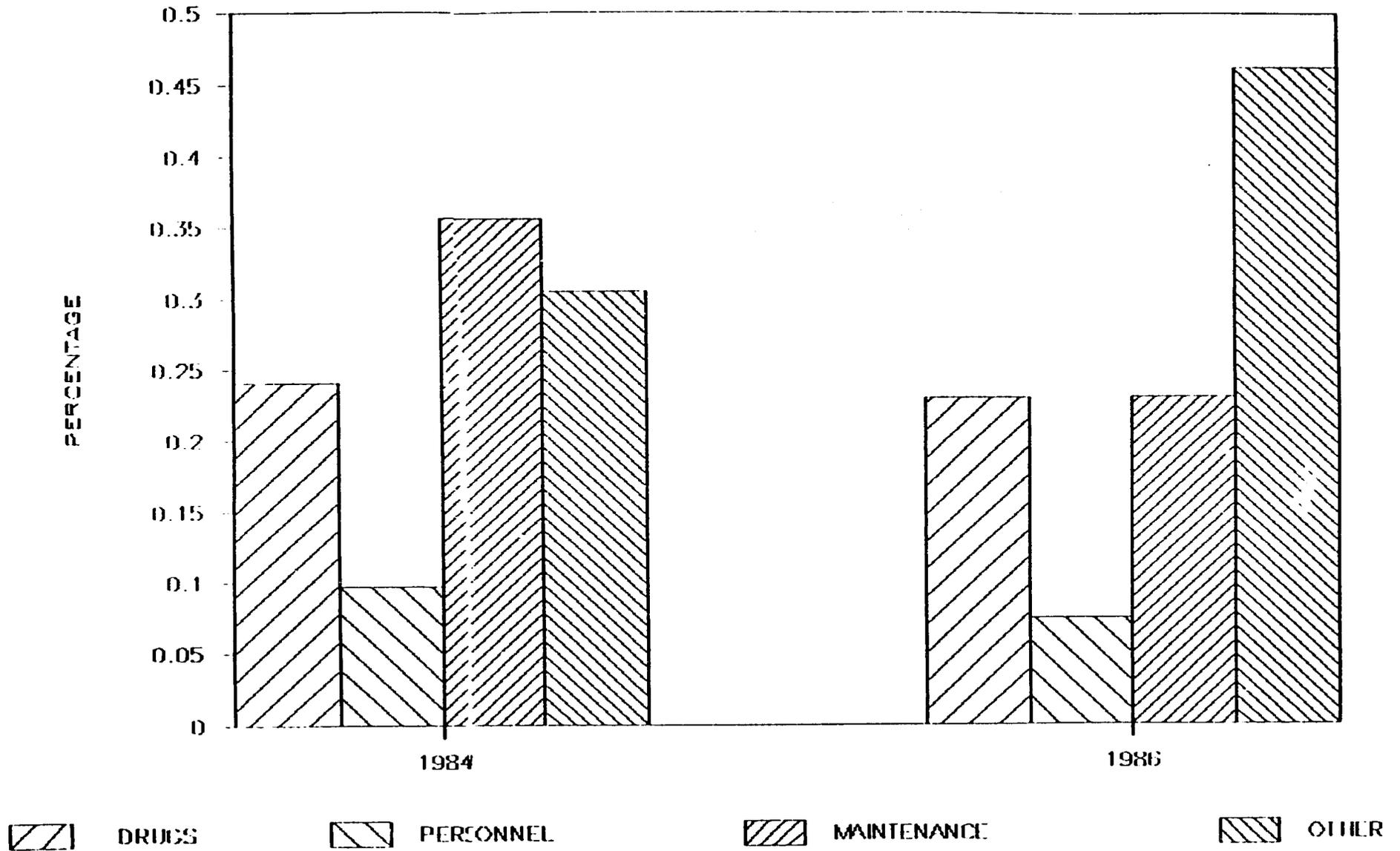
The National Laboratory, N.S. de la Altagracia, and Contreras Hospital have all sharply increased their expenditures over the period. The others' expenditures have virtually remained the same. During this period, Contreras Hospital's debt has grown by over 2000 percent (see Table 5), which is in keeping with the observed rise in expenditure, since its budget has not increased. The National Laboratory and N.S. de la Altagracia Hospital have both undertaken refurbishing, which have required additional outlays in recent years.

The trends suggest that revenues and other sources of funds have only allowed facilities to continue their expenditures; however, the debt levels at most of the hospitals also indicate that they have used deficit financing to cover expenses in the recent past. Even if hospitals' overall financial resources from budgets, revenues and charity remain the same, debt repayments will claim a certain portion of those resources and thus constrain their ability to increase expenditures. Robert Reid Cabral Hospital is a good example of this. Between 1985 and 1986 they eliminated their DR \$155.455 debt and their overall expenditures fell. Thus although revenues, donor contributions and "Patronato" activity has

Figure 4

PERCENT ALLOCATION OF RESOURCES

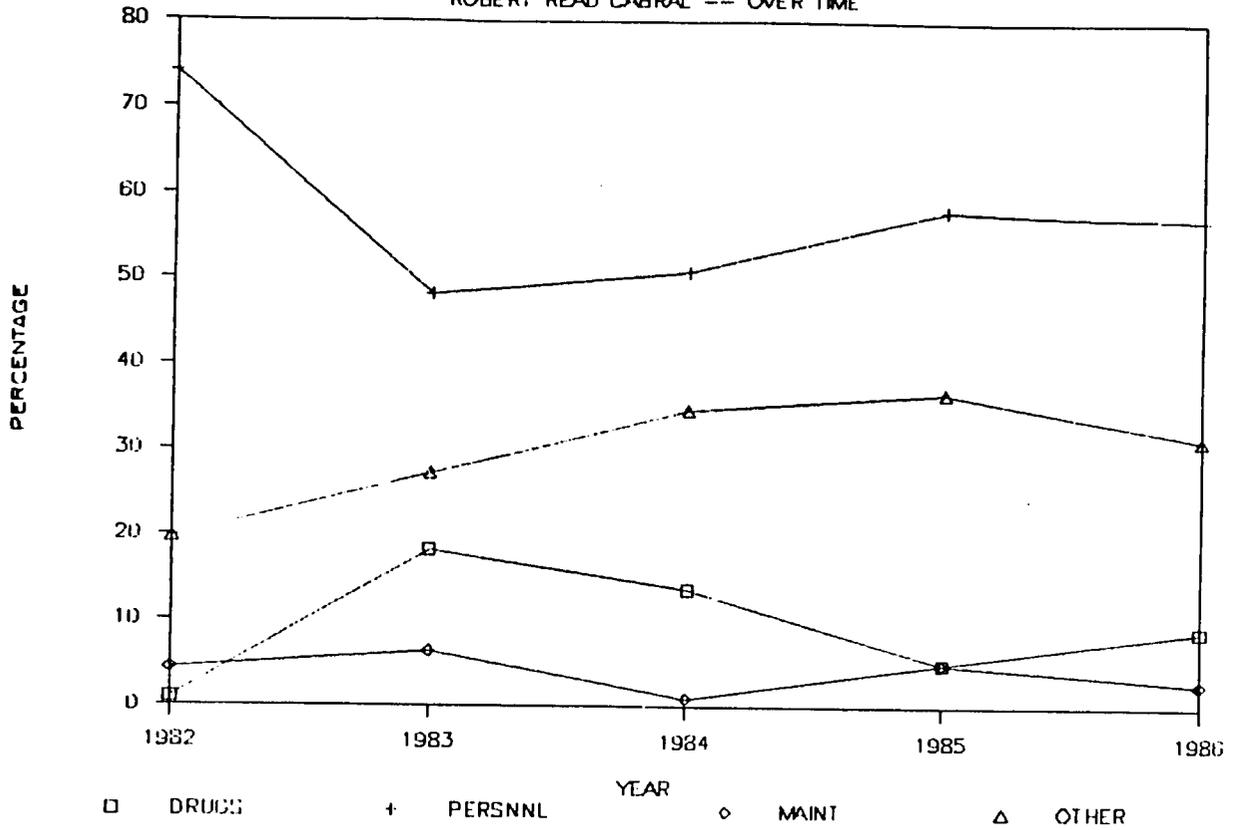
ALL HOSPITALS, EXCLUDING NAIL LAB



916
Figure 5

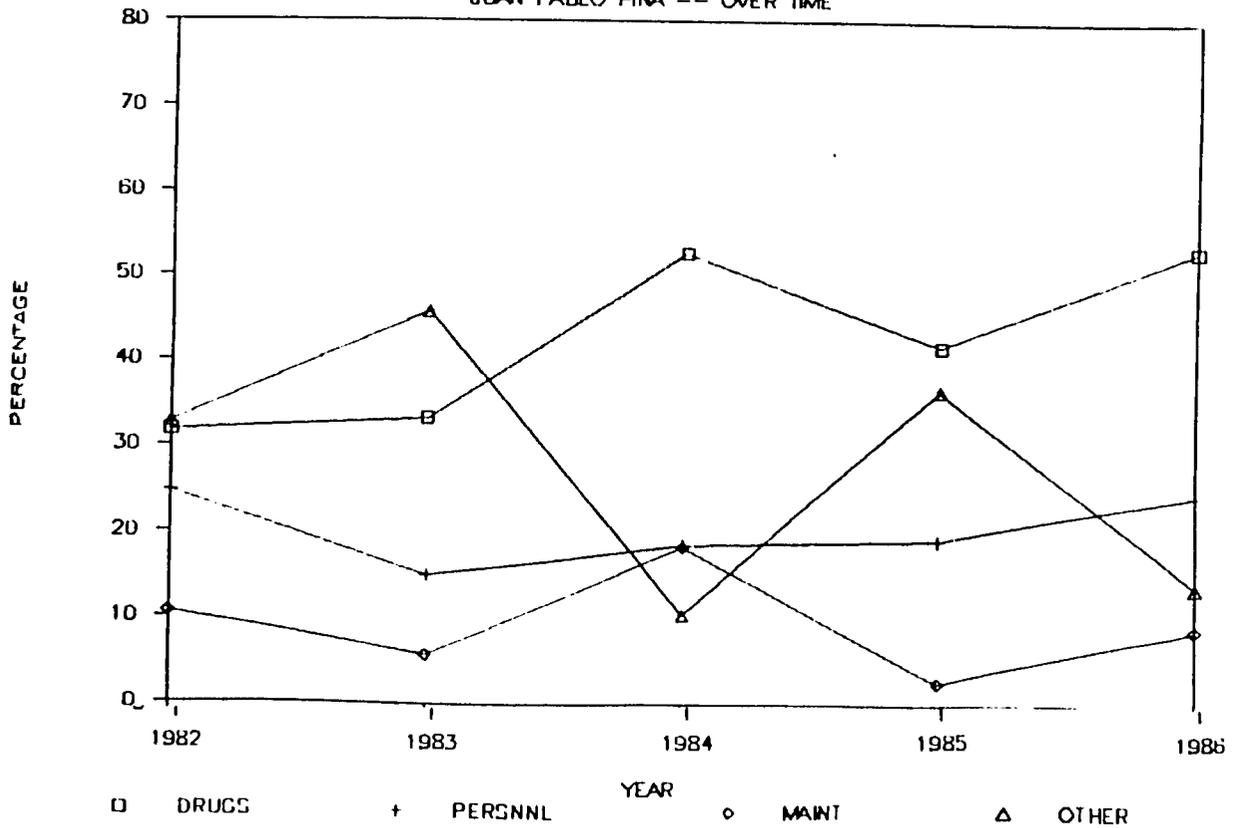
PERCENT ALLOCATION OF RESOURCES

ROBERT READ CABRAL -- OVER TIME



PERCENT ALLOCATION OF RESOURCES

JUAN PABLO PINA -- OVER TIME



in general increased, expenditures have not necessarily kept pace because of the accumulating debt burden that needs to be repaid.

The shifts in allocation of discretionary revenue are modest over time. Figure 4 summarizes the aggregate changes across hospitals between 1984 and 1986. The National Laboratory is excluded because its much larger earnings skew the distribution to the "other" category because of its considerable construction work and emphasis on supplies, both "other" categories in Figure 4. Personnel (ie., additional staff and salary supplements) and maintenance have decreased somewhat and "other" has risen between 1984 and 1986, due to Aybar Hospital's new policy of allocations to gastroenterology (where allocations across categories are not stipulated) as well as increases in expenditures on food and supplies at some hospitals.

Figure 5 shows trends in the allocation of hospitals' resources. The allocation of discretionary revenues for Juan Pablo Pina and Robert Reid Cabral Hospitals between 1982 and 1986 does not change much. While there is some variation, the relative importance of each expenditure category remains. Since 1983, Robert Reid Cabral Hospital's drug allocation has declined every year. This is attributable to its establishment of a subsidized pharmaceutical store in the hospital where patients could purchase the drugs the hospital did not have, thereby relieving the hospital of allocating its discretionary resources to drugs. The sharp shifts in Juan Pablo Pina Hospital's "other" category is unexplainable, but, in general its relative position appears to be falling as the other three categories of drugs, personnel and maintenance rise.

These discretionary hospital revenues raised from fees and charity provide the marginal resources to help keep facilities operating at a minimally acceptable level. Basic inputs such as personnel, drugs, supplies, and maintenance receive the bulk of these funds at most facilities and represent essential elements of proper operation. The National Laboratory, for example, has raised quality dramatically in terms of the speed and accuracy

of tests and has increasingly attracted private patients. Fee revenues have ensured availability of supplies, adequate and appropriate staff and functioning infrastructure at the National Laboratory.

Revenues are the central component for quality assurance at the National Laboratory because salaries are tied to performance, and because improved services have raised demand, despite the highest fees in the SESPAS system and frequent fee increases. The allocation of revenues to salaries allows a much more market-oriented staffing arrangement at the National Laboratory. The need for technical, non-physician skills assists this practice, which provides the director with the resources to both hire needed staff and reward performance of government personnel. Revenues are thus allowing public health facilities to supplement their operating budgets, which have fallen in real terms over the three-year period under study, and to continue to provide services.

Means Testing

Every health facility in the sample has a method for waiving fees for those unable to pay even modest charges. Patients who feel they cannot pay are interviewed by a social worker who decides, based on a socio-economic assessment, family size, home address, and various qualitative factors whether full or partial payment is warranted. Some facilities (Contreras and Robert Reid Cabral Hospital) keep detailed accounts of these efforts and the final decision on each patient, and others have no idea of the volume.

Table 8 summarizes the information on patients excused for payment in five facilities between 1984 and 1986. N.S. de la Altagracia estimates that during that three year period one percent or fewer did not pay any part of the fee and even fewer paid a reduced fee. The National Laboratory, with imprecise information on who pays, requires that all patients pay something, and the social worker estimates that about half of the patients receive a discount. At Dario Contreras Hospital, where data registration is the most complete and accurate, between a quarter and a third of patients do not pay the full charge, and between

TABLE 8

Proportion of Patients Excused from Fee Payment at Selected Hospitals, 1984-1986

	1984		1985		1986	
	Paid Less than Fee	Did Not Pay	Paid Less than Fee	Did Not Pay	Paid Less than Fee	Did Not Pay
Carl George ^a	20.0	50.0	20.0	50.0	20.0	50.0
Dr. Dario Contreras	25.8	27.3	32.9	30.0	34.1	26.5
Maternidad. Nuestra Senora de la Altagracia	0.04	0.9	0.06	1.0	0.02	1.0
National Laboratory ^a	50.0	0.0	50.0	0.0	50.0	0.0
Robert Reid Cabral ^b	10.8	37.8	8.1	58.5	9.3	36.1

a. Estimates from social worker and director.

b. X-rays only. Other services will have fewer patients who make full or partial payment, because the screening practices are less effective.

26 and 30 percent are excused from payment, which means that fewer than half pay the full price. Robert Reid Cabral Hospital's x-ray department has a larger proportion who do not pay anything but fewer who pay partially. In 1984 and 1985 the proportions who paid the full fee were about equal in the two hospitals, but in 1986 cost recovery increased sharply, especially in Robert Reid Cabral Hospital.

Based on this small sample, at a maximum, hospitals will waive payment for up to about sixty percent of their patients, and reduce the fee for up to about half. Carl George Hospital, with only general estimates about payment waivers, has about 30 percent of its patients paying full fare. How reasonable that is is difficult to say given limited information on the catchment area and the quality of the screening process. All three factors will affect exoneration policy and effectiveness, but are issues beyond the scope of this paper.

These data suggest that a significant portion of patients who use public hospitals are not charged, but, no data are available on the characteristics of that subpopulation that does not pay or receives discounts. How useful this system is in administering means tests is therefore not evident. Although the system is a possible method for screening patients, its effectiveness has not been determined. No information on any of the patient evaluation criteria is recorded, which prevents assessment of its applicability and efficiency as a means test. Without any income data or even socio economic characteristics, anyone's payment could be waived without anything more than the social worker's or the director's recommendation. Thus all that can be said is that there is a system for addressing the government's equity concerns, criteria for determining ability to pay are established, and some patients' fees are waived, or partially waived, although it cannot be said that it is those who cannot pay that receive the waiver. In theory, because every facility has a mechanism for determining whether and how much a patient should pay, those who cannot afford even modest fees will receive care, provided the hospital has the supplies and staff to provide it. Without careful evaluation this assumption remains an assumption, but it is reasonable to expect that it is a functioning if imperfect means test.

Conclusions

The Dominican Republic is experiencing an economic downturn that has resulted in a shrinking government budget and declining resources for public health. SESPAS's operating budget allocations to public hospitals has remained close to constant over the past five years, during a period of increasing inflation and substantial population growth. The result has been implicit incentives to hospitals to raise funds from other sources so proper functioning of public facilities can continue. Among the methods used to increase resources are user fees, which has been the single biggest source of supplementary funds for all but the national children's hospital, Robert Reid Cabral, which has relied more heavily on its "Patronato." Charity and debt financing have also been relied upon to help hospitals cover their recurrent costs.

The Dominican user fee experience is really a case of each hospital's management team developing and implementing means to cover rising operating costs. Every facility devises its own means of survival without guidelines or regulation, and without benefit of experience elsewhere either from other local hospitals or from other national experiences. The result is a wide variation in fee structures and vastly different levels of earnings. Although this somewhat anarchic system has produced significant revenues, the lack of auditing and information across facilities is troublesome. While the autonomy of the facilities is desirable as an incentive to raise resources from those who can pay for outpatient services, the lack of regulation and especially financial oversight leaves the system open to abuse. Moreover, under the current system, directors are unaware of successful user fee experiences elsewhere in the system or efficient criteria for setting charges.

The experience has demonstrated what approaches are particularly effective in raising revenues. User fees are primarily for outpatient, curative care, and are priced well below comparable services in the private sector. Pricing decisions vary, and some appear better than others. Charging something for every service is important. For instance, nominal

consultation fees raise considerable revenue because they are assessed on almost every outpatient. Cabral y Baez and Maternidad Hospitals raise more revenues from DR\$.50 and DR\$.30 consultation fees, respectively than they do from x-ray and laboratory fees combined. Revenues are purely a function of volume in both cases. Similarly, the National Laboratory assesses charges for all services and waives fees for no one, although they provide discounts to almost half their patients. Thus the comprehensive nature of fees (i.e., no services are free) as well as charges on high volume services are important to maximizing fee revenue.

From an efficiency perspective prices should reflect cost, but the criterion also can contribute to higher revenues, based on the successful experience at the National Laboratory and Cabral y Baez Hospital. Moreover, setting fees in relation to costs allows facilities to consistently meet a specific proportion of their operating requirements. Since the current system generally results in modestly priced services subsidizing more costly ones (even aside from outpatients subsidizing inpatients), a more efficient system where costs of service are the basis for fee levels would allow resource use to reflect their real value and contribute to cost recovery. The existence of a waiver system separately addresses equity. Thus efficiency in pricing can improve operation and influence utilization, and equity concerns can then be addressed as a separate concern. Currently the two objectives are combined and addressed simultaneously.

Public systems implicitly value all inputs equally for patients since patients are so rarely expected to pay anything. Thus costly imported equipment is valued equally with domestically produced materials because there is no price attached to them. Fees based on costs deter overutilization of those services that are more costly and encourage use of less expensive alternatives. Where public health resources are as scarce as they are in the Dominican Republic, such a policy may be critical to continuing the supply of basic services.

The issue of ability to pay and the need to take equity considerations into account have been addressed in every facility. All have a screening system that waives payment or reduces fees for patients unable to pay the set charges. In the few facilities with data, at least 30 percent pay the full fee, and typically a much larger proportion do. If nothing else, this experience suggests that an established system exists to ensure that those who cannot pay will still receive health care. The only drawback is uncertainty regarding who does and doesn't pay since there are evaluation criteria but no data on whose charges are waived.

The major limitation of the user fee system is the fact that outpatients subsidize inpatients, and the incentives are to use emergency services or admittance to the hospital to avoid charges. Given the costs of inpatient care, the deteriorating real value of government transfers, and the shortage of resources in public hospitals, some system of inpatient fees are warranted. Moreover, the existing method for ensuring that all citizens have access to care regardless of their ability to pay, in theory, provides a built-in safeguard to minimize abuses. If outpatients are expected to help facilities cover costs, then inpatients could and should do the same, especially since the current system has outpatients subsidizing inpatient care.

Facilities' expenditures of discretionary revenues raised from individuals and charity have been allocated to basic inputs of health care, including drugs, equipment, supplies, personnel, and maintenance. These inputs can enhance productivity and raise morale, because lack of complementary inputs reduces effectiveness and productivity, and by extension staff morale. On the margin these funds are key to making public facilities function.

User fees are helping to improve health care in public facilities and at the same time hospitals are attempting to meet the government's commitment to equity. The lack of oversight from the center has been, on net, a beneficial element by providing facilities a free hand in experimentation. Continued latitude will be beneficial to most hospitals, although

discussion of alternative revenue-raising options and perhaps general incentives, such as meeting a certain proportion of the operating budget, could prod those facilities that have been less successful or interested in raising their own funds. However, the most important issue to emerge here is the need to expand charges to inpatients who can pay for services.

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