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PRIVATIZATION IN THE JAMAICAN HEALTH SECTOR

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Privatization in the Jamaican Health Sector

The government of Jamaica has launched a broad set of privatization efforts in the hospital sector. These initiatives range from divesture of hospital components to outright leasing arrangements with private firms that will be fully responsible for operating and managing specific facilities.

Background

Privatization in the Health Sector

Although the privatization of parastatals and other productive sectors where government's role is questionable has proliferated over the past decade, health care delivery is perceived quite differently and little if any privatization has occurred in this sector in developing countries. Donor and country reviews of experiences with privatization has totally excluded health because of the lack of meaningful or documented experience.

What is Privatization

Privatization means "to turn over a Federal [public] activity, or part of a [public] activity, to a non-Federal entity[, and] allowing Government to provide services without necessarily producing them" (Presidential Privatization Cost Control, 1984). In health care that means that the private sector cannot only deliver services directly to patients and receive remuneration from them, but also can work for the Government in carrying out its obligations of providing services. Moreover, this can mean either an entire system becomes private and the government purchases all services from private providers, or it can mean simply Government's contracting out

activities that public employees once did. The Jamaican experiences and proposals are more heavily weighted toward the side of having the private sector carry out its objectives.

Government and Health Care Delivery

Government has taken some responsibility for health in all modern societies. Society expects government to regulate, oversee and underwrite the costs of care for some segment of the population. In the U.S., the most private of the world's health systems, the government finances about 40 percent of all health care, primarily for the indigent and the elderly; however, the U.S. government delivers less than 10 percent of all care. In Europe, government is usually the financier and deliverer of care, and at least 90 percent of all citizens obtain fully subsidized care.

Much of the burden on government is actually pressure to ensure accountability, some degree of efficiency in the health system, and equal access to health care for all citizens. Thus even in the U.S, hospital construction permits and certain other regulations bring government directly into the process of resource allocation in the health sector. Containing costs was the driving force behind the Canadian system and in the U.S. incentives through Medicaid are aimed at increasing efficiency and controlling costs. Virtually every country has some means of subsidizing health care for the poor.

Because government is viewed as ultimately responsible for the population's health, government involvement in health care delivery in most societies has frequently been all encompassing. Jamaica's health care system, based on Britain's National Health Service, is a cradle to grave system that covers the entire population. Macroeconomic difficulties and a rapidly growing

population have combined to undermine Jamaica's public health system by reducing the resources available for the sector. Moreover, the British model has recently faced its own difficulties with continuing to provide comprehensive health care to its citizens, which suggests that even well off countries cannot afford expansive, costly programs without incentives to contain costs and restrict subsidies.

Jamaican Approaches to Privatization

Jamaica has already taken some important steps toward a new approach to public health care provision. The privatization of hospitals, the divestiture efforts of the National Maintenance Unit and of certain hospital services, and revision of hospital user fees, which allow facilities to retain (some portion) of the revenues, are radical initiatives by developing country standards. Moreover, these major departures are occurring within a few years of one another. Jamaica is moving forward on many financial fronts with no blueprint or experiences to draw on.

Much of the impetus for the current moves are in response to severe deterioration in government facilities, an inability to improve circumstances through the earlier model and the realization that government resources cannot meet the full demand for health care services. Funds are simply inadequate to finance quality health care for all citizens. In 1977 (?), Prime Minister Seaga established the Ogle Committee to assess how to best raise resources in the health sector. The option ultimately pursued is privatization, that is, how to bring private incentives and management to bear to improve the efficiency and effectiveness of health services. Through raising management capability of the hospitals, attracting and keeping competent professional

staffs and shifting some of the government's burden for health care delivery to the private sector, the GOJ expects to improve services and save money. Greater patient reliance on private providers would allow public funds to be concentrate on citizens unable to pay for services.

As outgrowths of that decision, two separate efforts are being pursued. The first is the divestment of nonmedical and nontechnical services in particular facilities and privatizing the services currently under the National Maintenance Unit. The second effort is a more radical initiative designed by the Ogle Committee that will privatize three hospitals under three different models. Eventually a fully privatized system is envisioned that will be guided by the experiences of the three privatized hospitals. Each of these efforts is discussed separately below. The coordination and tracking of the privatization efforts is being undertaken by the Alternative Financing Secretariat in the Ministry of Health.

Divestiture

Hospital divestiture of nonmedical services was launched in 1987. Three areas of hospital service are slated for divestiture including: (1) housekeeping, janitorial and portering; (2) catering (i.e., food services); and, (3) laundry. Each of the divestiture initiatives is or will be introduced in the three major hospitals in Kingston: Kingston Public Hospital, Victoria Jubilee Maternity Hospital, and Bustamente Hospital for Children; Spanish Town Hospital; Cornwall Regional Hospital; Bellvue Psychiatric Hospital; and, Kingston School of Nursing.

The divestiture process has involved a number of difficult and complicated steps, including Cabinet approval to make existing government employees

redundant, negotiating an acceptable settlement with government employee unions, and rearranging Ministry of Health responsibilities in oversight of hospital services.

In October 1987, the government workers in the housekeeping services of the three Kingston hospitals were made redundant and provided with severance leave and pay, and the private contractor — selected through a formal bidding process — took over housekeeping, janitorial, and portering services. Prior to the transfer of responsibility, a thorough cleaning of the much neglected facility was completed. After five months of operation, the quality of the environment is obvious, morale has reportedly risen, and the government is save about J$374 million, or half its annual budget, on these services. The facility is clean, better maintained, and basic functions such as grass and shrubs are being introduced and maintained by the contractor.

The smoothness of the transition is attributed to the careful planning of the Ministry. In particular, negotiations with the unions was successfully accomplished and the promised severance pay and severance leave were made available as promised. Moreover, the dilapitated state of the facilities made it impossible for the union representatives to defend the quality of services being provided by government employees. Minor demonstrations outside the facilities occurred at the time of transition, but these were shortlived and contained.

Catering services are in the process of divestment. The Ministry received four bids in February for providing catering services to the three Kingston hospitals in response to its solicitation. This second phase should be operational in the next few months. Prior to the shift, the government had planned to refurbish the catering infrastructure; however, due to delays the

refurbishing will not take place until later in 1988. All four bidders agreed to operate with the existing equipment and kitchen until then.

The privatization of laundry services is planned for mid-1988. Equipment and the laundry areas will also be renovated and updated prior to the transfer.

A similar process is planned for the other hospitals listed above. USAID has agreed to clean, refurbish, and replace Spanish Town Hospital's housekeeping, catering and laundry infrastructure and equipment. Since none of these has been replaced since the hospital's construction in 1952, these improvements will be a prerequisite to contracting out for services.

In order to facilitate the transition, certain key staff will be retained (e.g., the morgue janitor) for some period of time because of the specialized nature of their functions The three or four month transition period with existing staff will ensure that vital functions continue even if a replacement is eventually put in place. The initial contractor can and has hired some of the redundant government employees on a more permanent basis.

In collaboration with the Ministry of Health, each hospital will go out for bids individually for each of the three services, which suggests that some combination of Ministry and hospital oversight for these services is essential. This poses a potential problem of regulation and establishment of performance standards. The current plan is to have the hospital boards that are appointed by the Minister of Health to oversee the operation of the hospital establish standards, and manage and evaluate contractor performance.

The Ministry of Health's National Maintenance Unit will be scaled back to a cadre of specialists within the Ministry, and hospital equipment maintenance service will be contracted out. This initiative has not yet been completed.

Thus, the political environment for divestiture exists, and the divestiture has been successfully established for five months in one service area of three tertiary care facilities. The completion of all three services in the six facilities is progressing and should be completed in 1989.

Privatization of Public Hospitals

The government is looking to privatization to increase efficiency and reduce costs, improve management, raise quality of health care in public facilities, and share the delivery and cost of health care with the private sector. The privatization concept and the means of achieving the objective was originally proposed and designed by the Ogle Committee. The current plan is to experiment with three different privatization arrangements to determine which of these is the most appropriate and cost effective model to serve as a basis for a revamped private oriented structure for public health care delivery in Jamaica. The full privatization of the public health care system would occur over an extended period of time to allow orderly transition and adoption of a cost effective system.

Three separate experiments are envisioned under the Ogle Committee recommendations: (1) management of a hospital in a single parish with the entrepreneur assuming all financial risks. A contract for five years would be drawn up with an option for extension upon review; (2) management of a hospital by a private group in one parish with the Ministry of Health assuming the financial risk. A three year contract would be negotiated with the possibility of extension upon review; and, (3) establishment of a parastatal hospital with private operation, management and control but with government holding a majority share.

Under the three privatization experiments, the Ministry of Health is looking to the private sector to provide certain preventive and curative health care services to a defined population and government will only subsidize the needy. Currently that entails contracting with private firms to operate but not own a hospital and its infrastructure and equipment.

In each of the experiments, the government would capitate the indigent and pay a partial capitation fee for the near indigent on a sliding scale basis. The company could operate the facility on a capitation or fee-for-service basis. The precise mechanisms for operation have not yet been worked out, but the general structure of each experiment is determined.

Health Facilities Trust[1]

The Ogle Committee has proposed the establishment of a Health Facilities Trust (HFT) to provide a structure for a private delivery of service with public responsibility. A trust would allow the government to own facilities without operating them, place management decisions outside the public sector, meet government's commitment to public employees, and upgrade personnel and the physical plant and equipment of public hospitals.

The functions of a HFT would include:

- ownership of the government's land, buildings, equipment, furniture, and hard and soft furnishings, which would be leased to a private contractor;

- responsibility for expansion, upgrading and maintenance of facilities;

1/ This section draws heavily on Philmore Ogle's "Proposal for a Health Facilities Trust."

- raising capital and borrowing money, using government assets as security but without government guarantees;

- employing physicians, nurses and some medical technicians; and,

- entering into contract for operation of health facilities by private sector enterprises.

Thus the Health Facilities Trust could borrow and authorize expenditures of funds to enhance, upgrade or replace existing infrastructure. Any improvements or acquisitions made by the contracted company would be approved and financed by the Trust and thereby remain part of the government's assets. The Trust would act as the employer for physicians, nurses and some medical technicians. Nontechnical staff would be hired by the private contractor directly. In all cases, the selected contractor would have the option of retaining existing staff, and would cover their government retirement and insurance costs. In cases where staff were not kept, the Trust would provide a holding position for those employees until they could be transferred elsewhere in the public system. This holding arrangement is to be financed through earnings from the management company's rent payments.

The Trust allows maximum flexibility to the contractor while retaining government's ownership of assets. Moreover it allows government to honor its commitment to employees without constraining the private contractor's initiative. Thus it maximizes maneuvering room and minimizes constraints while at the same time meeting public objectives.

The HFT will be guided by two classes of trustees, Supervisory Trustees who are responsible for ensuring compliance with the trust and setting overall direction, and Executive Trustees who are responsible for the custody of trust property and executing directives of the Supervisory Trustees. The Supervisory Trustees would be composed of a majority nominated by the Minister of Health and a minority of members representing other organizations to be determined. There will be an Executive Trust for each region

The Health Facilities Trust will adhere to overall policy objectives of the Ministry of Health through the oversight of the Supervisory Trustees; however, the Trust's personnel and employment policies will not be subject to government regulations. Issues such as fees, will be discussed by the Trustees, but the specific mechanism on fee setting and other financial questions have not yet been proposed.

A Trust arrangement was selected because of the ease of creation and the difficulty of dismantlement. A trust is not a legislated body and dissolution of a trust requires that it can be demonstrated that the Trust can no longer provide benefits to its beneficiaries.

The "Proposal for a Health Facilities Trust" is under review by the Ministry of Public Service and the Attorney General for conformance with Jamaican law and policy. An extensive survey in 1987 in St. Catharine parish attempted to assess the population's ability and willingness to pay for health care. Information on income, employment, health insurance coverage, health care utilization, and quality of health care was collected, and the population was questioned on their hypothetical ability and willingness to pay (more) for health services, or obtain insurance coverage. Outstanding issues on the extent of household indigence in the hospital catchment area is being undertaken by the Statistical Institute.

Concurrently with these other activities a request for proposal is being drawn up under contract by an outside firm, based on preliminary guidelines devised by the Ogle Committee. The three experiments are expected to be sent out for bids at roughly the same time in order to allow a maximum opportunity of comparison across the experiments.

Issues in Privatization

The privatization proposals and experiments are well planned and carefully designed. The issues of oversight criteria and methods for evaluating the efficiency and effectiveness of alternative privatization options or of the divestitures are still unresolved. Some attention needs to be given to considering how the public sector will regulate the contractors and how the latter will be assessed. Similarly, given the government's strong desire to obtain guidance from these experiments in revamping the public health system, some standardized method(s) for evaluating the alternative approaches is vital. Moreover, assessments from the onset are important since direct comparisons are contemplated.

The biggest possible outstanding question on the privatization of facilities is the degree of interest of private enterprises and some sense of what constitutes a potentially profitable endeavor for private firms. Some variant on a bidders conference is warranted to determine whether a viable plan is being proposed and where the possible roadblocks exist in currying the interest of private enterprises. Such a discussion could help to finalize a realistic offering for privatizing three public facilities.

The proposals and actions taken offer creative and important means for dealing with insufficient resources in the health sector. They may well serve as blueprints for other countries attempting to address resource constraints through greater reliance on the private sector. In the process, the Jamaican health system will develop a broader financial base, and hopefully raise the quality and efficiency of health care services.