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USER FEES IN PUBLIC FACILITIES:
A COMPARISON OF EXPERIENCE IN
THE DOMINICAN REPUBLIC, HONDURAS AND JAMAICA

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**Resources for
Child Health
Project**

REACH



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I. INTRODUCTION

A financial crisis confronts the public health systems of many countries in Latin America and the Caribbean. The Ministries of Health in the region, historically, have both provided and financed health services for the majority of the population. However, throughout the late 1970s and first half of this decade, the economies of these countries have faced sustained stagnation or deterioration in their rate of economic growth. The overriding economic difficulties center round low or negative rates of growth, declining exports, burgeoning debt, mounting fiscal deficits, and increasing rate of inflation. Budgetary pressures have generated austerity requirements to reduce government spending and have resulted in measures to decrease expenditures in most sectors. Reduced resources for meeting national health goals, in both real and nominal terms, are a pattern familiar across the region. Tables 1-5 illustrate these difficulties for the region and for specific countries.

Given the seriousness of the resource constraints, governments and their health ministries face three possible strategic options. One strategy is to tolerate a deterioration in the quality, quantity, and coverage of health services; another option is to look for mechanisms to improve efficiency and increase productivity; a third strategy is to search for new sources of revenue. Most countries are likely to use some combination of all of these options. To date, the experiences of individual countries have not been adequately documented.

Table 1

**GROWTH OF GNP IN THE DEVELOPING MARKET ECONOMIES OF THE
WESTERN HEMISPHERE**

	1961-73	1974-80	1981	1982	1983	1984
Regional Performance	4.8	6.0	0.7	-1.4	-2.6	2.6
Selected Countries						
Brazil	6.9	6.8	-1.6	0.1	-3.2	4.5
Mexico	7.7	6.2	7.9	-0.5	-5.3	3.5
Peru	4.5	2.4	3.9	0.4	-10.9	4.8

Source: UN and World Bank in Lance Taylor, 1986 "Developing Countries in the World Economy--Macro Effects of the Second Takemi Symposium on International Health", May, 1986.

Table 2

**TRENDS IN CENTRAL GOVERNMENT OPERATIONS
Overall Deficit/Surplus as Percent of
Total Expenditures and Lending Minus Repayments**

Country	1977	1980	1983
Argentina	-16.4	-17.2	-45.0
Barbados	NA	NA	-3.9
Bolivia	-7.5	-37.2	-60.1
Brazil	-3.7	-9.8	-11.7
Chile	-3.4	18.8	-8.7
Colombia	5.7	-13.3	-20.3 *
Costa Rica	-15.7	-29.3	-8.4
Dominican Republic	0.0	-15.3	-17.8
El Salvador	8.4	-33.5	-30.9
Guatemala	-8.0	-25.8	-26.7
Honduras	NA		
Jamaica	-40.4	NA	NA
Mexico	-20.2	-16.5	-29.7
Panama	-17.9	-17.0	-28.6
Paraguay	5.5	3.0	3.6
Peru	-17.2	-3.7	-17.5
Trinidad & Tobago	NA	8.2 *	NA
Uruguay	-5.6	0.2	-15.3
Venezuela	-16.8	-2.4	-11.1
Western Hemisphere	-11.0	-11.7	-23.7

* 1981

Source: Government Finance Statistics Yearbook, 1985.
Volume IX, IMF

Table 3

COUNTRY	TOTAL GOVERNMENT EXPENDITURE AS A PERCENT OF GROSS DOMESTIC PRODUCT		
	1977	1980	1983
Argentina	15.5	19.1	20.3
Barbados	32.4 (FY 77/78)	30.9 (FY 80/81)	29.3 (FY 83/84)
Bolivia	12.6	13.8	10.5
Brazil	18.7	19.0	20.2
Chile	32.0	28.0	31.9
Costa Rica	19.3	25.0	24.5
Dominican Republic	14.6	16.9	13.7
El Salvador	13.9	17.2	16.9
Guatemala	10.8	14.3	12.9
Honduras	17.6	19.8	NA
Jamaica	33.8 (FY 77/78)	40.6 (FY 80/81)	NA
Mexico	15.4	17.5	26.1
Panama	31.4	32.7	37.7 (1982)
Paraguay	11.1	10.1	11.8 (1982)
Peru	18.6	21.1	18.9
St. Lucia	27.8 (FY 78/79)	36.1 (FY 80/81)	36.1 (FY 83/84)
St. Vincent	27.9 (FY 77/78)	31.7 (FY 79/80)	33.9 (FY 82/83)
Trinidad & Tobago	24.6	30.2	NA
Uruguay	23.4	21.8	24.5
Venezuela	27.1	22.0	27
Western Hemisphere	18.1	19.9	19.8

Source: Government Finance Statistics Yearbook, 1985, Volume IX, IMF.

Table 4
EXPENDITURES FOR PUBLIC HEALTH SERVICES
AS A PERCENTAGE OF TOTAL GOVERNMENT EXPENDITURES

COUNTRY	1977	1980	1983	1985	1986
Argentina	2.8	1.8	1.4	1.8*	1.3*
Barbados	10.6 (FY 77/78)	11.2 (FY 80/81)	10.6 (FY 83/84)	NA	NA
Bolivia	8.0	12.1	3.1	1.5*	1.4*
Brazil	6.9	6.5	7.3	7.6*	6.4*
Chile	6.9	7.4	5.6	6.1	6.0
Costa Rica	25.4 (1978)	32.7 (1982)	22.5	22.5*	19.3
Dominican Republic	9.0	9.3	10.6	16.3*	9.0*
El Salvador	9.8	9.0	8.4	5.9	7.5
Guatemala	7.6	7.6 (1979)	NA	NA	NA
Honduras	8.4	8.0	NA	NA	NA
Jamaica	7.8 (FY 77/78)	NA	NA	NA	NA
Mexico	4.4	2.4	1.2	1.5*	NA
Panama	14.5	12.7	13.1 (1982)	NA	1.4*
Paraguay	2.7	4.0	3.7 (1982)	5.8*	15.8*
Peru	5.9	4.5	6.2 (1982)	NA	3.1
St. Vincent	13.9 (FY 78/79)	11.8 (FY 82/83)	11.3 (FY 82/83)	NA	NA
Trinidad & Tobago	7.8	5.8	5.9 (1981)	NA	NA
Uruguay	3.8	4.9	3.4	4.1	NA
Venezuela	8.0	8.8	8.6	7.6*	4.8
Western Hemisphere	5.5	5.0	4.7	NA	8.1*
				NA	NA

* Data are from different year than indicated

Source: Government Finance Statistics Yearbook, 1985, Volume IX, IMF.
World Bank, World Development Report, 1987, 1988.

Table 5

TRENDS IN MINISTRY OF HEALTH PURCHASING POWER
AS ESTIMATED BY PAHO

COUNTRY	1980	1981	1982	1983	1984
Argentina	100	76.3	50.7	107.5	NA
Bolivia	100	103.5	86.7	80.4	NA
Brazil	100	90.0	104.7	NA	NA
Costa Rica	100	101.0	65.9	(51-73)	--
El Salvador	100	89.5	73.3	68.8	59.1
Guatemala	100	119.2	112.2	73.1	68.2
Honduras	100	106.8	116.1	100.9	87.1
Peru	100	97.3	108.5	108.8	NA

Source: PAHO, 1985. "The Economic Crisis and Its Impact on Health and Health Care in Latin America and the Caribbean", Provisional Agenda Item 6: Executive Committee of the Directory Council, Washington, D.C., December, 1985.

Empirical data collected from the public health systems of the Dominican Republic, Honduras, and Jamaica offer a comparison and contrast of the relative merits of the third option in responding to the financial crisis. The public health systems in these three countries have long subscribed to the philosophy that health care is a right and that the state should provide free public services to meet the health needs of the population. Yet within this approach, all have tolerated fee-for-service charges for some services and for certain categories of clients. The purpose of this paper is to compare and contrast the operational experiences of these countries with the collection of user fees in public hospitals. Our intent is to contribute to a body of relevant and systematic information which can be used to establish realistic expectations and guidelines for user-fee systems.

II. COUNTRY PROFILES

A. Basic Indicators

The World Bank classifies the Dominican Republic, Honduras, and Jamaica as lower middle income countries. Reported population for the Dominican Republic was 6.6 million, 4.5 million in Honduras, and 2.4 million in Jamaica (World Bank Development Report, 1988). In relation to the physical size of each country, population density was highest in Jamaica and lowest in Honduras. Basic health indicators for Honduras and the Dominican Republic reveal similar patterns. Life expectancy at birth in 1986 was 66 in the Dominican Republic and 64 in Honduras. Infant mortality rates for the respective countries were 110 and 128 per 1,000 live births in 1965, and were reduced to 67 and 72 by 1986. Jamaica, in contrast, had a life expectancy of 73 years in 1986 and an infant mortality rate that had declined from 49 per 1,000 live births in 1965 to 19 per 1,000 in 1986.

Table 6 summarizes some basic information regarding the economies of these countries. Honduras was the poorest of the three countries, according to the 1985 World Development report, with a per capita income of US\$670 (1983 dollars); per capita income was US\$1300 for Jamaica and US\$1370 in the Dominican Republic. Between 1965 and 1983, GNP grew at an average annual rate of 3.9 percent in the Dominican Republic. Honduras and Jamaica were not as fortunate. During the same time period, growth of GNP in Honduras averaged only 0.6 percent per year, while in Jamaica growth was a negative 0.5 percent. Inflation and external debt have presented difficulties for all three

economies. From 1965 through 1980, annual inflation rates for Honduras and the Dominican Republic, were 6.3 and 6.8 percent respectively, while annual inflation for Jamaica averaged 12.8 percent. Since 1980, both Jamaica and the Dominican Republic have suffered higher inflation rates. Jamaica averaged 19.8 percent per year between 1980 and 1986. Unofficially, inflation in the Dominican Republic has averaged above 25 percent per year (Lewis, 1986). Inflation in Honduras has remained modest at 5.2 percent annually. External public debt increased during the decade in all three countries. The increase has been most pronounced in Jamaica where debt service as a percentage of GNP increased from 6.9 percent in 1983 to 20.8 percent in 1986. In the Dominican Republic, debt service as a percent of GNP increased from 2.8 percent to 5.9 percent, while in Honduras it increased from 4.3 to 5.6 percent.

Table 6
ECONOMIC INDICATORS

COUNTRY:	DOMINICAN REPBULIC	HONDURAS	JAMAICA
PER CAPITA GNP (1983 US DOLLARS)	1,300	670	1,370
GNP (1965-1983)	3.9	0.6	-0.5
INFLATION RATES: (1965-1980)	6.8	6.3	12.8
(1980-1986)	5.2	5.2	19.8
DEBT SERVICES AS % OF GNP:			
1983	2.8	4.3	6.9
1986	5.9	5.6	20.4

Source: World Bank Development Report, 1986, 1988

B. Public Health Systems

Honduras

The Honduran Ministry of Health is expected to provide health services to 85 percent of the national population. Its facilities for delivering these services, as of December, 1985, included 3,669 hospital beds which were distributed as follows:

1) nine small area hospitals	578 total beds
2) six regional hospitals	907 total beds
3) five national hospitals	2184 total beds

Lower level facilities included 111 large health centers and 482 small centers. In 1985, these facilities provided a total of 12,980 hospital discharges, which was an increase of 6.3 percent over 1984. Also in 1985, ambulatory patient visits for all health facilities totaled 3,378,903, a decrease of 4.4 percent over the previous two years.

Since 1975, the guiding policy of the Ministry of Health has been to emphasize extension of basic primary health care services and coverage. Commitment to this policy is evident in budgetary allocations. Between 1983 and 1985, hospital costs rose by three percent per year; allocations to primary health care programs, however, increased by over 14 percent. Nevertheless, PAHO estimated that by 1984, the purchasing power of the Ministry of Health budget had eroded by over 12 percent since the beginning of the decade (see Table 5, page 5). Per capita health expenditures in 1982 were US\$15.74 and were reduced by 17 percent to US\$13.09 in 1984 (in 1982 dollars).

Dominican Republic

The Secretariat for Public Health and Social Welfare (SESPAS) in the Dominican Republic is expected to provide health services to 80 percent of the national population. Effective coverage is around 67 percent (Harrison, 1984, MSH report). In March 1987, its facilities for delivering services included 46 hospitals and 55 lower level health centers and subcenters distributed over seven regions and in the national capital area. Specialty hospitals in Santo Domingo and the regional hospital in Santiago provide specialized diagnostic and treatment services. The total number of beds in 1983 was 9,814.

The SESPAS health budget was eight percent of the national budget in 1982, but by 1985 had declined to five percent. In real terms, however, the decline was 15 percent for the 1983-86 period (see Table 4, page 4). PAHO estimated that per capita expenditures, measured in 1982 dollars, declined by nine percent during the 1982-84 period.

Jamaica

Jamaica's public health service delivery system is expected to provide services to all citizens. In 1987, its facilities for delivering these services, exclusive of the University of the West Indies Hospital, included 4,991 beds in 24 hospitals and 447 primary health care clinics. Hospital beds are distributed across the following categories:

- 1) 1079 beds in 11 Type C hospitals delivering basic inpatient and outpatient care;

- 2) 749 beds in Type B hospitals providing basic medical care and some specialty services;
- 3) 840 beds in Type A hospitals providing a full range of secondary and tertiary services;
- 4) 2323 beds in Specialty hospitals (maternity, psychiatric, chest, hospice and rehabilitation).

In 1987-88, these facilities provided an estimated 119,701 discharges and 327,325 outpatient visits.

The Ministry of Health share of the national budget declined from 7.5 percent in 1982-83 to 6.1 percent in 1985-86. In nominal terms, the budget grew by 56 percent over the 81/82-85/86 period. Given the high inflation rates during this period, however, the real value of the budget resources allocated to health declined by 38 percent. This erosion represents a decrease in real per capita health expenditures of 44 percent. While the real value of public health resources declined, patterns of resource allocation shifted with an increasing share allocated to primary health care programs. Between 1982/83 and 1986/87, hospital and support services fell from 75 to 68 percent while the budget share allocated to primary health care rose from 18 to 24 percent.

The contrasts and similarities among these different approaches to delivering services are summarized in Table 7.

Table 7
HEALTH SERVICES DELIVERY

	DOMINICAN REPUBLIC	HONDURAS	JAMAICA
PER CAPITA HEALTH EXPENDITURE TRENDS 1982 - 1984	-8.6%	-16.8%	-17.8%
NUMBER OF HOSPITALS	46.0	20.0	24.0
HOSPITAL BEDS PER 1,000 POPULATION	163.6	81.5	208.0
NUMBER OF LOWER LEVEL FACILITIES PER 1,000 POPULATION	0.83	13.2	18.6

Source: PAHO, 1985, "Health Conditions in the Americas", 1981 - 1984, Volume I.

C. DATA COLLECTION

To examine the policy framework with respect to user fees, data were collected from the Ministry of Health in Honduras, SESPAS in the Dominican Republic, the Ministry of Health in Jamaica, and from selected public hospitals in each of the countries. Changes in government policies and procedures (or new interpretations of previous policies) with regard to user charges in hospitals occurred in each country between 1982 and 1986. Specific and detailed information on data collection is available in the individual case study for each country (see Overholt, 1987; Lewis, 1987; Lewis, 1988).

D. HOSPITAL FINANCIAL CRISIS

The financial pressures which confronted the Honduran, Dominican Republic, and Jamaican governments in the early 1980s required their public health systems to accommodate to reduced government resources. Table 8 presents the changes that occurred in central government budgetary allocations for selected hospitals in the three countries (time period is 1983-85 for Honduras, 1984-86 for Dominican Republic, 1983/84-85/86 for Jamaica).

In the case of Honduras, we see an erosion of resources in all hospitals which derives from two sources. The first erosion occurred as a reduction in central government budget allocations. Only one hospital, Salvador Paredes, experienced an increase in its total budget allocation but that increase was less than one percent. Total budgets for all other hospitals either did not grow or were reduced in nominal terms over the two year period. The unweighted average reduction for the two year period was 1.9 percent. The second source of erosion occurred as a reduction in purchasing power due to inflation. The annual inflation rate during this period was over eight percent. Therefore, all hospitals experienced a real decline in their budgetary resources during the two year period of over 16 percent.

Table 8

CHANGES IN BUDGET ALLOCATIONS, SERVICE STATISTICS, FEE REVENUE
(Percent Change)

Country	Non-Personnel Budget	Total Budget	Number Outpatient Visits	Number of Discharges	Fee Revenue	Supplier Credit
HONDURAS (1983-1985)						
Escuela (NH)	NA	-1.4	-8.2	8.6	15.1	
Santa Teresa (R)		-1.6	2.5	-0.4	38.4	
Leonardo Martinez (R)	NA	-1.7	3.1	-9.0	194.9	
Del Sur (R)		0.0	-3.5	5.1	-1.2	
Occidente (R)		-2.0	-62.8	8.4	-3.4	
Atlantida (R)		-2.0	-9.8	15.3	18.9	
San Francisco (R)		-3.6	-14.1	3.1	74.6	
Gabriel Alvarido (A)		-1.6	9.5	12.0	12.5	
Santa Barbara (A)		-2.2	11.5	-11.4	2.2	
Manuel S. Subirana (A)	NA	-0.7	-5.4	17.1	52.8	
Tela (A)		-2.5	-9.6	-23.8	12.4	
Salvador Paredes (A)		0.7	-14.1	14.2	87.0	
Tocoa (A)		-3.1	9.0	-14.1	-13.2	
DOMINICAN REPUBLIC (1984-1986)						
Robert Reid Cabral (S)	27.3		17.2		90.6	-100.0
Dr. Dario Contreras (S)	0.0	NA	-12.4	NA	6.3	2611.5
M.S. de la Altagracia (S)	0.0		-14.2		24.8	-13.3
Carl George (R)	0.0		12.2		21.4	15.5
Jaime Mota (R)	0.0	NA	-13.5	NA	-1.3	0.0
Juan Pable Pina (R)	12.6		-14.2		29.7	-32.3
J.M. Cabral Y Baez (R)	18.1		-14.7		103.4	2.8
Dr. Luis Aybar (G)	12.5		13.3		185.8	31.4
JAMAICA (by regions) (by regions) (1984-1986)						
Kingston		19.8				
Cornwell Regional	NA	NA			NA	
St. Thomas		5.3			500	
Princess Margaret		NA			500	
Port Antonio		2.6			over 1000	
Port Maria		19.1			NA	
St. Anns Bay		28.0			126	
Montego Bay		26.1			-	
Sur La Mere		1.3			-35.4	
Mandeville		14.5			NA	
Spanish Town		30.1			29.9	
Liguanea		1.3				

NH = National Hospital
R = Regional Hospital

S = Specialty Hospital
G = General Hospital

A = Area Hospital
NA = Not Available

* Average inflation rates per period: Dominican Republic 25%, Jamaica 20%, Honduras 8%

The situation for eight hospitals in the Dominican Republic is similar with respect to their nonpersonnel budgets. The annual inflation rate for the time period exceeded 25 percent. Although budgets increased in four of the hospitals, none increased above the implied inflation rate of 50 percent. The erosion of budgets for the remaining hospitals was equivalent to the inflation rates since their nominal budgets remained the same.

While all hospitals in Jamaica experienced increases in their budgetary allocations during the three year period, the increases were substantially below the implied inflation rate of 60 percent. All hospitals, therefore, faced a real budgetary decline of 30 to 60 percent, a significant erosion of resources.

Hospitals in all three countries appear to have used increased collection of user fees to respond to their resource constraint problem. Table 8 presents the changes in fee revenue that occurred as budgetary resources diminished. Most hospitals in the three countries achieved modest to substantial growth in fee revenue. In the case of Honduras, fee revenue grew substantially above the implied 16 percent inflation rate in five hospitals and slightly above it in one hospital. Hospital fee revenue grew at a rate well above inflation rates in three Dominican Republic hospitals. For the region hospital areas in Jamaica, fee revenue rose substantially in all regions except Sav La Mar where it declined.

Although fee income has increased, the total amounts of revenue collected, nevertheless, remain small in absolute terms. Table 9 presents hospital fee revenue for individual hospitals in relation to operating budgets. When the amount of revenue is considered as a percent of the total recurrent budget, revenue represents less than 10 percent of the total budget. However, when it is considered as a percent of non-personnel portion of the budget, several hospitals in each country are doing quite well.

Table 9

USER FEE REVENUE AS A PROPORTION OF OPERATING AND TOTAL BUDGETS:
DOMINICAN REPUBLIC, HONDURAS, AND JAMAICA

COUNTRY HOSPITAL	REVENUE AS PERCENTAGE OF:	
	TOTAL BUDGET	NON-PERSONNEL BUDGET
DOMINICAN REPUBLIC (1986)		
Carl George	2.8	15.5
Dr. Dario Contreras	8.0	18.6
Jaime Mota	0.7	5.1
Jose Maria Cabral y Baez	3.1	11.7
Juan Pablo Pina	2.6	11.0
Maternidad, Nuestra Senora de la Altagracia	2.5	10.2
Dr. Luis E. Aybar	1.3	3.9
National Laboratory	NA	181.0
Dr. Padre Billini	NA	16.7
Robert Reid Cabral	0.1	2.9
HONDURAS (1985)		
Hospital Escuela	3.7	7.9
Santa Teresa	6.7	15.6
Leonardo Martinez	5.5	12.3
Hospital del Sur	3.6	9.5
Hospital del Occidente	1.1	2.6
Hospital Altantida	4.6	12.3
San Francisco	7.6	18.8
Gabriel Alvarado	8.1	16.5
Santa Barbara	3.2	7.2
Manuel J. Subirana	5.1	11.1
El Progreso	6.7	16.3
Peurto Cortes	2.4	5.0
Hospital Tela	7.5	20.5
Salvador Paredes	5.7	16.1
Tocoa	7.0	17.1
JAMAICA (by regions 1985-1986)		
Kingston	3.1	9.8
Liguanea	3.2	5.7
Mandeville	2.6	27.4
Montego Bay	3.5	10.3
Port Antonio	3.1	18.2
Port Maria	2.1	6.6
Sav-La-Mar	2.8	7.2
Spanish Town	5.9	18.5
St Ann's Bay	8.5	24.1
St. Thomas	3.2	16.0

Source: Lewis 1987, 1989; Overholt 1987

Hospitals have made other responses to the financial crisis. For those hospitals where information was available, Table 8 (see page 14) presents changes in service statistics that have occurred during the same time period. Service statistics reveal that utilization declined for many hospitals in Honduras and the Dominican Republic during this period of budgetary erosion. However, the limited information makes it difficult to draw definitive conclusions regarding the relationship between changes in budget allocations and changes in utilization. In Honduras, either outpatient visits or total discharges declined in hospitals; in the Dominican Republic, reduced outpatient visits decreased in most hospitals. Fees may have discouraged use in Honduras, although fee adjustments were minor in most hospitals during the period. In the Dominican Republic, broken equipment and the lack of supplies, especially pharmaceuticals, have limited the extent and quality of services. Reduced utilization may have been attributable to deteriorations in the perceived quality of service rather than a resource to user fees. During this time, several articles appeared in the local press which discussed the apparent increase in services provided by private practitioners and the decline in visits to public facilities. Both of these phenomena were attributed to the deterioration in the quality of public services.

III. GOVERNMENT POLICIES TOWARDS USER FEES

Honduras, Jamaica and the Dominican Republic have relied on user charges in their health systems for a long time. Their policy approaches, however, have been different, as is revealed in Table 10.

Dominican Republic

Government policies have contributed to a diverse set of experiences with user fees in hospitals across the Dominican Republic. Two factors are important. The first concerns the legal environment. The constitution of the Dominican Republic guarantees "free medical assistance and hospitalization to those whose economic resources require it." The interpretation of this guarantee has generated sustained disagreement and controversy over whether health services should be free to all citizens. However, a 1940s law implicitly authorizes fees for certain services. Thus, for several years, government policy has not allowed fees for inpatient services except for private beds in a few hospitals, but has tolerated the use of fees for outpatient services. A second factor is the considerable autonomy that hospital directors have in raising resources for the hospital from "donations". The combination of this autonomy with the absence of a clear policy and guidelines for fees has provided hospital directors with a free hand in raising and spending funds. Thus, fees in Dominican Republic hospitals have evolved ad hoc in response to the perceived needs and the initiatives of hospital directors.

Table 10

GOVERNMENT POLICIES FOR USER FEES

Country	Policy Toward User Fees	Responsibility for Fee Setting	Central Government Oversight
Dominican Republic	Official policy is that no fees are needed or charged. Inpatient charges are prohibited.	Each hospital sets fees for outpatient services with no knowledge of other facilities's actions. Some hospitals have private rooms or wings.	Limited knowledge, no interference and no auditing by central authorities in collection or allocation of revenue.
Honduras	Central Ministry encourages individual hospitals to collect fees, but provides no guidelines or criteria for fee schedules.	Each hospital establishes their fee schedule for inpatient and outpatient services. Private beds and wings are not permitted. No charges are made for drugs.	Central government collects and audits revenue but does not control allocation of expenditure. Hospitals can draw on deposited revenues as needed within a fiscal year. Subject to prohibition for certain categories of expenditures. Unexpended funds cannot be carried forward to next fiscal year.
Jamaica	A schedule of fees was introduced in 1985 and as of early 1986 hospitals were allowed to claim revenues back for hospital operation.	A standardized fee schedule applies to all facilities differentiating public and private patients, and stipulating criteria for waiving charges. Private wings exist in most hospitals.	Fees are collected and turned over to the Ministry of Health and are returned on the basis of a submitted budget allocation proposal.

Source: Lewis 1987, 1989; Overholt 1987

Honduras

In Honduras, government policies towards user fees similarly have created a diverse set of experiences. In the early 1950s, a government decree gave hospitals and health centers the authority to collect "symbolic" fees from nonprivate hospitalized patients and outpatient consultations. Early implementation of user charges was unsystematic and at the discretion of the individual hospital. The hospital managed and controlled the collected revenues. Since the early 1970s, the government has required hospitals to report their weekly revenues to the Ministry of Finance and deposit the funds in the Treasury. However, hospitals have retained the exclusive right to spend the fee revenues they deposit, subject to certain government restrictions. One important restriction is the prohibition of spending user fee revenues for salary payments for professional and technical personnel.

In the early 1980s, when the Ministry of Health faced serious problems meeting its recurrent costs, it focused renewed interest on fees as a means to sustain hospital operating costs. A 1983 policy directive from the Ministry of Health informed hospitals that supplements to hospital budgets could no longer be accommodated by the government and hospitals were encouraged to augment their budgets through user fees. The type and range of fees that are currently in place are presented in Table 9 (see page 17).

Jamaica

User charges in Jamaican public hospitals have been in effect since the early 1960s, although suspended briefly between 1972-73. Fee schedules were established by the central government, and hospitals were required to be remit all revenues collected to the general tax coffers (the Consolidated Fund). In addition, hospital budgets were reduced by the amount the hospital had collected. Given the extraordinary disincentive that these policies created for hospitals to collect fees and the depth of the government's financial crisis, reform measures were undertaken in 1984. Fee schedules were revised, hospitals were allowed to claim half of the collected revenues for their own use, and the hospital budget allocations were not to be affected by revenue collection. Table 9 (see page 17) summarizes the government fee schedule. Fees charged at public hospitals are modest compared to the private sector. However, the schedule stipulates that "patients covered by health/accident insurance policies shall pay the fees payable by private patients or the maximum payable under the terms of the policy, whichever is greater". A 1987 adjustment to these reforms allowed hospitals to retain the full amount of collected revenues.

The services that carry fees and the amount charged vary widely. Table 11 illustrates the type and range of fees in use. Fees rarely exceed 10 percent of private sector prices for similar services, and frequently are far less.

Table 11

COMPARISON OF FEE SCHEDULES
(in US\$)

SERVICES	DOMINICAN REPUBLIC (1)		HONDURAS (2)		JAMAICA (3)	
	MINIMUM FEE	MAXIMUM FEE	MINIMUM FEE	MAXIMUM FEE	PUBLIC PATIENTS	PRIVATE PATIENTS
Outpatient Consultation	0.02	0.13	0.41	1.63	1.01	1.01
Laboratory Basic Exams	0.27	3.24	0.20	2.00	1.01 - 4.06	4.06
Complex Exams	0.27	10.81	0.40	6-61	10.14	10.14
X-Rays	1.35	20.27	2.00	20-61	1.01 - 2.02	1.01 - 2.02
Other Medical Procedures	0.54	2.70	2.00	20.00	4.06(a)	4.06(a)
Maternity	None	--	6.12	4.29	10.14	30.42(b)
Operating	None	--	None	--	4.06 - 24.34	4.06 - 24.34
Inpatient Admissions						
Area Hospitals			4.08	19.28	5.08(c)	10.14(d)
Regional Hospitals	None	--	0.40	16.33	6.08(c)	10.14(d)
National Hospitals			--	14.28	6.08(c)	10.14(d)

- (a) Average Charge
 (b) Plus 10.14 Per Day
 (c) Per Admission
 (d) Per Day

(1) Fee schedule as of March, 1987; exchange rate August 1987 US\$1 = DR\$3.70

(2) Fee schedule as of December, 1987; exchange rate September 1987 US\$1 = Hon.\$2.45

(3) Fee schedule in 1984; exchange rate annual average 1984 US\$1 = J\$4.93

Source: Lewis 1987, 1989; Overholt 1987

These differences in policies affect the level fee revenue collected. What is interesting is that Honduras, the poorest of the three countries has higher fees and better performance on collection than either of the other countries which are far less poor.

IV. COMPARISON OF OPERATING SYSTEMS

The independence and autonomy of the fee systems for these countries can be described on a continuum, with Jamaican facilities having the least autonomy and independence and the Dominican Republic having the greatest. Table 12 compares their operations. Reporting, recordkeeping, monitoring and surveillance are more developed in Jamaica and Honduras than in the Dominican Republic. Jamaica has the most cumbersome administrative system. All countries have worked out mechanisms for providing services to the indigent. Jamaica's system is the most formal and relies on a means test developed for food stamp recipients, a mechanism operated outside of the Ministry of Health.

Table 12

OPERATING PROCEDURES FOR MANAGEMENT AND CONTROL
OF REVENUE COLLECTING AND EXPENDITURES

COUNTRY	CONTROL AND MANAGEMENT OF REVENUES	EXPENDITURES OF REVENUES	METHODS FOR AND EXTENT OF FEE WAIVERS
Dominican Republic	Hospitals retain all revenues collected at the facility. Internal auditing is poorly developed. Expenditure decisions are made by facility. No other approvals are required.	Between 9% and 82% of revenue is spent on drugs; 3% to 37% to maintenance and 13% to 30% for supplies. Facilities vary widely in expenditure priorities.	Social worker and/or hospital director interview patients and decide on full or partial fee waivers. Between 1% and 50% pay nothing and between 0.5% and 50% pay less than the designated fee.
Honduras	Hospitals report revenue to Ministry of Finance and deposit receipts with Treasury on weekly or monthly basis. Ministry of Health must approve expenditures.	Regular salary payments are especially prohibited. General supplies, surgical supplies, and unskilled labor and overtime receive between 37% and 70% of average hospital allocations.	Social workers or the hospital director interview patients and waive fees according to SES criteria. Twenty percent of patients are waived at the tertiary care hospital.
Jamaica	Collection and monitoring procedures are not standardized across facilities. All revenues are sent to Ministry of Health and facilities are reimbursed after submitting a detailed request to the Ministry of Health	Maintenance, supplies, and equipment are the major purchases, with maintenance receiving 100% in some hospitals.	All food stamp recipients have fees waived; other patients can request a waiver from the assessment officer. Hospital managers estimate that 50-65% of patients pay designated fees.

Source: Lewis, 1987, Lewis, 1989, Overholt, 1987.

V. CONCLUSIONS

The comparison of the user fee experiences of the Dominican Republic, Honduras, and Jamaica underscores the feasibility of charging for services in public health systems to mobilize resources. The very real budgetary constraints imposed on hospitals in these countries have motivated them to experiment with user fees. We also see that government policy toward user charges matters in terms of impact on incentives for collecting fees, levels of earnings, and effects on utilization. The incremental revenues obtained have contributed to maintaining the quality and quantity of services or have slowed the deterioration of publicly provided services. User fees, therefore, can contribute to resolving the policy dilemma that many governments now face in financing the public health sector.

The Ministries of Health in these three countries, and the facilities themselves, have gained much useful knowledge from their experiences with charging for services. Guidelines and criteria for establishing prices for services, determining exemptions for payments, and establishing collection procedures would be important additions to all three systems. Future efforts need to be devoted to developing and refining administrative procedures and management systems for better utilizing this important resource.