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PRE-PAYMENT FOR HEALTH SERVICES IN JAMAICA: THE PROSPECTS FOR PILOT DEVELOPMENT

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Hopkins Holmberg

Executive Summary

This is the third consultancy which has examined the prospects for "low-cost health insurance" aimed at low and middle income consumers in Jamaica.

This consultancy finds there is a substantial opportunity to develop pilot programs which offer health service benefits on a pre-paid basis. The initial pilots would be developed at the Ministry of Health hospitals in Mandeville and May Pen. These hospitals have Chief Executive Officers who have been in place for more than a year; the hospitals participated in the first offering of the programme "BUILDING VIBRANT ORGANISATIONS: Effective Management of Health Delivery Systems." The hospitals are demonstrating managerial acumen and are building a positive reputation in the communities they serve.

They form a useful base for pilot pre-paid plans. Their strengths can make the plans possible; the success of the pre-paid plans will provide resources for further strengthening of the hospitals. In both cases they intend to link the pre-paid plan to the primary care service. Success of these pilots would provide a model which could be useful elsewhere in Jamaica outside the Kingston Metropolitan Region.

To pursue development of these pilots, further work by the consultant and the PSOJ insurance specialist will be necessary in May and June of 1994 toward having a well planned development path available by the end of June 1994.

If these pilots are successful, that experience might be subsequently combined with the many church clinics gathered in the Metropolitan Kingston Region under the InterChurch Association to develop a plan which would be appropriate to the situation in Kingston.

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A. Background

This paper is the result of a Consulting Agreement that runs from the 5th of April 1994 through the 30th of June 1994 under which specific Work Order Agreements can be authorized. One work order agreement has been authorized relating to work to be done from the 5th of April through the 29th of April 1994.

The purpose of this effort is for the Consultant to assist PSOJ (The Private Sector Organisation of Jamaica) to develop a viable scheme of insurance for health care which focuses on low and middle-income populations. The work is to build upon activities initiated in earlier consultancies.

Effectively, the Consultant is charged with determining whether there is a viable course which can lead to the development of pre-payment for health services in Jamaica. If pre-payment is viable, a clear path for future development needs to be designed. If not, a clear case needs to be made for the non-viability of that path.

The primary conclusion of this effort:

It is possible to develop successful pre-payment for health services in Jamaica. Originally this should involve the development of one or more pilot schemes.

This paper is, effectively, a work-in-progress. Full development of the pathway for the development of a successful pre-payment scheme for health services in Jamaica will require another visit by the Consultant, probably in the first half of June 1994. Thus, this paper is effectively a partial draft of the completed report which will be submitted by the end of June. In this version there is an enumeration of the activities which should be undertaken between now and the end of June.

1. Relevant aspects of Health Care in Jamaica

Jamaica is a middle-income country which once aspired to become a provider of social services in the model of the then "eastern block" of nations.

Historically, Jamaica has excellent traditions in health. The Government was able to provide care. The society was able to produce excellent nurses. During the 1970s and into the 1980s an excellent Primary Health Care System was developed. Even in the last half of the 1980s in the world sweepstakes for reduction of fertility, first place went to the People's Republic of China and second place went to Jamaica which did not have access to all of the tools which were utilized in China.

While Jamaica may have fared well in the fertility reduction sweepstakes, it was not faring well in other parts of health delivery.

Jamaica produces excellent nurses who easily qualify for licenses in Canada and the USA where wages are substantially higher. Economic stabilization in Jamaica has forced the reduction in purchasing power of the

budget of the Ministry of Health. At the wages being paid, many posts, especially in nursing, are vacant.

The hospital sector has been managed using the British "triumvirate" system which has generally been discarded elsewhere in the world because it is ineffective. Early in the 1990s the Ministry and the hospital sector have been characterized as an immobilized bureaucracy where very little happens.

The cure for these problems is found in more money and better management. Efforts are being made on both fronts. There have been, and currently are, a number of internationally financed projects which are endeavoring to change the situation.

- The Health Systems Improvement Project (HSIP) is a joint effort of the Government of Jamaica and US AID. It has a number of elements including this consultancy. One of the cooperating organizations is the Private Sector Organisation of Jamaica (PSOJ) which is the direct recipient of this consultive assistance.
- Efforts financed by the InterAmerican Development Bank are also an important component of the current change.

These efforts are making a mark in improvement of the management of the services of the Ministry of Health, in improving some of the physical facilities, and in providing better systems and perspective.

These efforts have had limited direct impact on improving the financial base for the provision of care. They have assisted in the process of inaugurating user fees which pay part of the cost of care provided by the Ministry of Health. These fees most impact those with lower incomes. This effort, as part of HSIP, is directed at inspecting the prospect for low cost health insurance.

2. Previous reviews

There have been two previous reviews of the potential for low-cost health insurance in Jamaica which have occurred under the general framework of the HSIP through LAC HNS.

a) McGriff

In April-May of 1993 there was a visit by Dene McGriff who was already very familiar with the operations of Blue Cross of Jamaica.

McGriff conducted interviews with insurers to determine their interest in participation in design and implementation of low-cost insurance schemes with the offer of technical assistance through LAC HNS. McGriff says he "met with all of the insurance companies operating in Jamaica except Mutual Life¹." He provides one-paragraph reports on contacts with four insurers: Alico, First Life, Life of Jamaica, and Blue Cross.

¹ Dene McGriff, Jamaica Trip Report (4/25 - 5/9/93) Revised, page 2.

In projecting necessary follow-on activities, McGriff points to the importance of a survey then contemplated by PSOJ (and subsequently completed) which would determine the amount people are currently willing to pay for coverage.

Although he enumerates possible follow-on activities, McGriff's basic perspective is: "Most 'low-cost' insurance schemes mean 'low-benefits' and high out-of-pocket costs, which do not benefit the lower or middle-income person."²

b) Schrefer

Another review, also primarily focused on existing insurers, was conducted by Philip Schrefer and resulted in a draft report dated February 26, 1994.³

Schrefer outlines some new developments since the review by McGriff and, toward other possible developments, points to possible projects such as an assessment of the feasibility of creating a Ministry of Health managed care pilot project, points to use of a possible national health insurance proposal being considered in Trinidad, and points toward the consideration of Jamaica replicating a drug purchasing system developed by the Organization of Eastern Caribbean States.

3. Preliminary Promise

This effort is, then, the third try. There hangs over it a sense "three strikes and you are out;" in this case: if there is not a positive course of action resulting from this consultancy, there will probably not be another consultancy on the subject in the near future.

In designing this study an effort was made to address the question more broadly. Effectively, the initial question was: is there any good prospect for developing a level-payment scheme which secures the right to an appropriate set of health services for broad segments of the population of Jamaica?

Two elements were used to construct an answer to that question: a study by PSOJ on receptivity to premiums, and a review of the costs of care in selected facilities.

a) PSOJ Study: Premium Tolerance

An important contribution is a study commissioned by PSOJ.⁴ In Phase II the study found that working, but uninsured, people located outside of the

² Dene McGriff, as previously cited, page 1.

³ Philip J. Schrefer, "Technical Assistance to Private Sector of Jamaica; Low Cost Insurance and Other Options", Draft, February 26, 1994.

⁴ "The Results of A Research Study of The General Working and Insured Population of Jamaica", Kingston: J.A. Young Research, Ltd., February 15, 1994, 112 pages.

Kingston Metropolitan Region were willing to pay J\$ 313 per month for health insurance.

"The benefit of paramount importance to the uninsured was full medical coverage for self and family. Other important benefits were dental and optical."⁵

b) Costs of Care

Knowing the working public is willing to pay as much as J\$ 300 per person, per month, for health insurance, the next question becomes: how much is the cost of providing that care?

For 1000 people	Public Patient Fees	Private Patient Fees	Estimate of Hospital Costs
2,000 visits	2000 @ J\$50 = J\$ 100,000	2000 @ J\$250 = J\$ 500,000	2000 @ J\$ 83.3 = J\$ 166,667
100 Admissions - Doctor	100 @ J\$ 200 = J\$ 20,000	100 @ J\$ 2000 = J\$ 200,000	
100 Admissions - Hospital ⁶	100 @ J\$ 315 = J\$ 31,500	100 @ J\$ 3500 = J\$ 350,000	
500 Days of Hospitalization			500 @ J\$ 500 = J\$ 250,000
50 Surgeries	50 @ J\$ 350 = J\$ 17,500	50 @ J\$ 3,000 = J\$ 150,000	
250 X-Ray and Lab	250 @ J\$ 50 = \$12,500	250 @ J\$ 250 = J\$ 62,500	
1,000 Rx	1,000 @ J\$ 30 = J\$ 30,000	1,000 @ J\$ 250 = J\$ 250,000	
Total for 1,000 people for a year	J\$ 211,500	J\$ 1,512,500	J\$ 416,667
Total for one person for a year	J\$ 211.5	J\$ 1,512.5	J\$ 416.7
Total for one person for a month.	J\$ 18	J\$ 126	J\$ 35

⁵ J.A. Young Study, cited above, p. 7.

⁶ The fees taken are at the mid-point between those stated for a level "B" and a level "C" hospital.

As a first approximation, data were used from the nine hospitals from the western half of Jamaica that participated in the first offering, during 1993, of a management development programme called "BUILDING VIBRANT ORGANISATIONS: Effective Management of Health Delivery Systems." The programme was developed and offered by Jamaica's Administrative Staff College (now the Management Institute for National Development) with the assistance of the Association of University Programs in Health Administration.

This data allowed establishing costs for ambulatory visits and days of hospitalization. It then became necessary to add estimates of the actual amount of such care that Jamaicans will actually use. The product of those two gave an estimate of the actual cost, per month, on the west of the island of the current service configuration of the Ministry of Health, which provides much ambulatory care and more than 90% of all hospitalization on the Island.

The current costs and estimated utilization combine to an estimated current cost of J\$ 35 per person per month. These costs are seen in the right hand column of the table. In the middle two columns are public and private patient fee levels for public hospitals; these have been reduced, using the same utilization estimates, to comparable estimates of cost per person per month.

With the public willing to pay in the vicinity of \$300 a month and cost being \$ 35 a month there seems to be some opportunity! Further investigation is indicated to be sure the opportunity is real, and to determine how best to realize the opportunity.

A subsequent test was performed using information which has been assembled by the Boston University Center for International Health as part of their work under the InterAmerican Development Bank Project. They estimate the total medical care expenditure in Jamaica, public and private, per capita is currently J\$ 3699, or J\$ 308 per person per month.⁷

4. Activity

The activity of this consultancy included five days of advance work during which the above comparison was developed and a reading a wide range of materials from other studies of health service delivery in Jamaica. During that time a plan was prepared for the effort during a week to be spent in Jamaica.

The encounters during the week of April 18-22 in Jamaica were designed to find relevant counsel on the possibility of developing some pre-payment scheme and checking with a wide variety of individuals who are positioned to challenge and provide assistance in surmounting challenges. A list of those contacted can be found in the annexed material.

The activity of the week was arranged by and conducted with the collegueship of Dawn Battick, the insurance specialist on the staff of PSOJ as part of the HSIP.

⁷ Boston University Center for International Health, "Preliminary Report: Jamaican Health Sector Expenditure-Based Analysis," Preliminary Report, as revised 7 March 1994.

The major findings of the week were:

- Two public hospitals which have the appropriate characteristics are very eager to undertake the development of a hospital-based pre-payment plan. They are very confident it will be of substantial benefit to the development of the hospitals, to the service of the members of the community they serve, and to the relationship between the hospitals and their communities.
- A future opportunity exists with the InterChurch Association which is building itself as a central representation for a wide range of church related clinic services in Metropolitan Kingston. They are currently building the central secretariat of the organization. They have identified 39 distinct church based health clinics; not all of them are current members of the InterChurch Association.
- Life of Jamaica was identified by previous consultants as being the insurance company which is most interested in developing a range of health related offerings. They are currently expanding the application of their existing pre-paid group practice offerings and are attempting to design a new, low cost, plan which is specifically aimed at the clientele of public hospitals. This provides a potential increase in the richness of the experience which can be gained and opens the possibility of having competitive low cost plans on the market at once at some sites; there is the substantial possibility that a competitive situation could lead to each competing plan being more successful than it would be if there was not competition.
- The consultant, Holmberg, and Battick, of PSOJ, were able to test their perceptions and understandings of the environment with a wide variety of individuals who have experience which is relevant to some aspect of the development of a pre-paid health plan aimed at low and middle income Jamaicans. In this calibration there were no surprises; there were a number of cases of multiple individuals underlining the same phenomena.

B. "Insurance" and "Prepayment"

The label "low cost health insurance" points toward a device which is aimed at low and middle income populations which changes their perspective on securing health care. Without such insurance, when these non-rich families and individuals face an episode of illness, it represents a potentially large expenditure which is un-planned and may seem impossible. The result can be delay in securing care, which can exacerbate the situation and increase its costs. Other results can include impoverishment of the family.

The image of "low cost health insurance" is of some device which allows these families and individuals to regularly pay a stable and affordable amount of money. In return they expect, when they encounter the need, to secure appropriate health services with a low, un-onerous, marginal cost.

1. "Insurance"

The use of the term "insurance" may mislead the dialogue. "Insurance" connotes preparation for financial events which are, at once, of very low probability but of quite high cost. Thus, we take insurance against the risk of a household fire although many of us will live whole lives without experiencing such a fire. The low probability of such an event combines with a high price to lead us to insure ourselves against the risk.

Likewise, we buy "life insurance." We know we are going to die, but we are concerned about the risk of pre-mature death and its financial implications for our survivors.

When we talk of "health insurance" we are discussing a device for paying the cost of health care when that event is of low probability and quite high cost. Yet, health expenditures are, in the main, of reasonably high probability and they are frequently not of very high cost. The average family will, in a year, encounter the need for at least one family member to secure some form of health care. The average family will not, in the same year, experience a premature death or the burning of their residence.

We don't need "insurance" as much as we need some form of level "pre-payment" for the health services we expect to utilize. Then, when we do need to access those services, our decisions will not be governed by the contents of our purse on a given day.

Insurance, in dealing with low probability but high cost events, must carefully provide for sufficient reserves to assure the ability of the insurer to pay should the low probability event actually occur. We have invented careful regulatory structures to assure the viability of our insurance industry.

This prudent regulatory structure is not generally relevant to service pre-payment. For instance, when buying a new capital asset such as an automobile or a television the dealer may offer us an "extended warranty" for a fixed, pre-paid, cost. Indeed, the auto dealer may include in the "extended service" package the cost of future changes in oil and oil filters. In this case the dealer is charging each customer the same amount and will experience some variance in use; some automobiles will require more parts than others. But the variance is entirely manageable by the dealer; there is no need to utilize the regulatory structure that was developed for fire insurance.

Likewise, the real cost to an airline is in the amount of weight it carries. But the airline chooses to charge us by the person, not by the kilogram; it assumes it will get an adequate total income to fly all of us, some heavy and some light. The use of health services is more analogous to pre-paid maintenance contracts and buying airline tickets than it is to casualty insurance.

Discussion of "Health Insurance" frequently leads to discussions with Life Insurance companies. In many cases, life insurers are primarily investment companies who happen to get the funds to invest through the sale

of policies that have a "savings" element in them. These very useful social enterprises have developed overheads and cost structures which are appropriate to the investment driven business in which they engage. That overhead is not necessarily applicable to finding a device for health service pre-payment for low and middle income citizens of Jamaica.

Thus, previous explorations of "low cost health insurance" have led to discussions with Life Insurers and with Blue Cross. This exploration is focusing on pre-payment and is open to vehicles other than use of registered insurance companies.

2. Not indemnity

Most commonly, insurance schemes pay on an indemnity basis. If something happens, they pay a specified amount or they pay the current retail price of the items or service which needs to be obtained to repair the damage. A great deal of expense goes into the process of paying many small bills and the process of judging the appropriateness of claims and preventing fraud.

In pursuing reasonably priced pre-payment for health care we are not necessarily interested in indemnity payments. In return for the amounts paid in, the customer expects service, not cash.

Moving from an indemnity benefit to a service benefit can reduce the cost of providing the service expected by the pre-paid customer and it can eliminate the process of filing, examining, and paying numerous small claims. As a result, pre-payment can lower the pre-payment fee which needs to be charged to that customer.

3. Managing care

When you buy pre-paid service for a machine, such as an automobile, you expect the company selling the service contract to keep the vehicle functioning. If something goes wrong, you expect them to repair it promptly. You are perfectly happy if they give you regular service including preventative maintenance and thereby reduce the need for unscheduled repairs.

You expect the automobile company to manage their affairs so that they keep your automobile functioning. As long as they keep you satisfied, you are pleased with every effort they exert to minimize their own costs.

Likewise, in providing care for the health of individuals, there are strategies which can work to minimize costs. When you are in a pre-paid care relationship, the pre-paid care provider has every incentive to manage your care for the maximum cost-effectiveness. Hospitalization is expensive, so they have incentive to use it wisely. Yet, in many cases, deferring care or under-caring can lead, ultimately, to increased costs. While there is an incentive to minimize costs consistent with maintaining satisfied customers, there is also incentive to be sure the customers remain satisfied, or the monthly pre-payments will be reduced.

4. Stability of expenditures

The major characteristic of an event which can be meaningfully handled by insurance is that the event should have a low probability and a high cost. Companies that insure against hurricane damage face a huge, seemingly infinite, expenditure in case of a hurricane.

Health care is more analogous to the impact of ordinary wear and tear on automobiles. Automobiles need regular servicing. On any given day automobile mechanics will be relatively busy with a small portion of the autos serving a society. We don't expect to see a time when all automobiles serving a society are all in need of major repair at once.

The Consultant spent five years in the 1980s as the CEO of a non-governmental teaching hospital in Nairobi. The employees of the hospital, and their dependents, had the best health benefits of any in the country; the benefits were for care produced by the hospital. The hospital formally accounted for all of this care by billing itself and writing cheques from the payroll account to the revenue account to pay for the care.

Care for employees and dependents was one of the most stable expenditure items in the hospital's budget. The water bill showed more month to month variation.

The group involved grew from about 600 to 900 employees, plus dependents. There is generally great stability in the consumption of care with groups of 1,000 or more. In one study of small pre-payment schemes, the smallest plan, operated by a single health center, an enrollment of 620 and was viewed as being "highly profitable. Over 50% excess revenue over expenses."⁸

An insurer might feel uncomfortable writing a portfolio that included 1,000 adjacent households which insured them for fire and storm damage; the high cost in case of the event of a major fire or storm would lead to prudent re-insurance. Yet, writing a portfolio for providing health services to the residents of those same households could be very comfortable.

C. Utilizing the Ministry of Health's Assets

More than 90% of the hospital capacity in the country is financed by the Ministry of Health. The Ministry runs an extensive, and historically effective, Primary Health Care Service.

Efforts at pre-payment for Health Care which are not based on the use of Ministry of Health facilities can assume to have the potential of making a major contribution on Jamaica only by building (or buying) massive physical resources for providing care.

To the degree that pre-payment can be made to work within the assets of the Ministry of Health, the model developed has substantially greater

⁸ Donald S. Shepard, Taryn Vian, and Eckhard F. Kleinau, *Health Insurance in Zaire*, Washington: World Bank Africa Technical Department, Working Papers, August 1990, page 11.

viability as a tool which can rapidly expand in Jamaica. Thus, in looking for possible opportunities for pilots we have a bias toward using both Ministry of Health Hospitals and the Primary Care System, provided they meet other criteria.

D. Necessary Assets

What are those criteria for being a participant in a pilot pre-payment scheme?

1. An Objective

No venture can succeed without being clear about its objective. The objective of this venture is:

To establish viable schemes of health pre-payment which can successfully serve low and middle-income individuals and families in Jamaica.

"Success" would involve continuously paying customers and participating service providers; both consumers and providers would have to be in sufficient numbers to spread fixed costs and keep the price attractive to both consumers and providers.

It would be a bonus if such schemes can be made to work through, or use, Ministry of Health capabilities because use of the Ministry of Health capabilities would provide the base for rapid expansion of this form of family health security.

2. Honored care givers

When consumers are offered the opportunity to purchase a health plan their first question is: who will provide my care? If the care-givers are not regarded as satisfactory, the likelihood of the consumer purchasing the health plan is very poor.

Indemnity plans, which offer to pay fixed amounts (after the fact) of bills from any licensed provider of service have an advantage because they will pay for all providers. The disadvantage of indemnity plans is the necessarily higher price which comes from paying high priced bills on an individual basis, and the relatively low proportion of the individual bill which is paid by a plan with low premiums.

In this effort we want to serve low and middle income individuals and families in Jamaica. A brief encounter with some private practitioners in Jamaica can cost more than the weekly wages for many low income Jamaicans. They could not afford the premium that would allow them to see any practitioner.

Thus, we want to have care providers who are amenable to financial relationships which allow for substantially lower premiums. Yet, the

consumers will still make a comparison: are those care providers worth the price?

At least two activities have helped to create conditions which will produce public honoring of care givers who can be embraced by a health plan aimed at low and middle income families and individuals:

- Chief Executive Officers have been placed in a minority of the Government's Hospitals. Ministry of Health hospitals previously all functioned on an old colonial model which involved three heads: a Senior Medical Officer, and Matron, and an Administrator -- all of whom reported to separate bosses in the Ministry of Health headquarters in Kingston. Jamaica may have been the last country in the Commonwealth to continue this system. Emplacement of CEOs has been supported by both US AID and the InterAmerican Development Bank Projects through the Kingston office of the Pan American Health Organization.
- An educational program developed with US AID funding through the HSIP entitled: *BUILDING VIBRANT ORGANISATIONS: Effective Management of Health Delivery Systems* which appears to be a constructive force in improving the management of Ministry of Health Hospitals. It was originally offered to nine hospitals from the west of the island in the first half of 1993.
- Hospitals that have both of the characteristics noted above, and some that have only one of these characteristics, have achieved a third, important status: despite their heritage as impoverished MoH facilities, they have begun to establish a positive bond with the communities they serve. This bond provides the basis for these hospitals being able to be viewed as "honored care givers" by citizens of their community who are considering the purchase of a health plan that involves being furnished services at, or through, the MoH hospital in their community.

3. Productive management

Providing health services which are consistently honored by the consuming community requires a productive managerial capability. Active, productive, management will be the assurance that the care giving unit is routinely attempting to maximize the product being realized from its resources.

An important activity of the productive management is pushing the care providers toward continual improvement. Lacking such productive management, the risk of the care givers not routinely being honored is too large.

4. A managing clinician core

When a physician is being post-paid for care they get paid (sometimes not) for the care they deliver. Their financial well being can be enhanced if they manage the care so that the patient bill becomes unnecessarily large, or if they manage the care by providing too little care which later results in a large, corrective, bill.

When you are pre-paid, the situation changes. Now the care givers are unable to be indifferent to issues of finance. They need to provide services in a way which keeps their premium paying customers happy. And in providing services they need to avoid spending, over all patients, too much. If they spend too much the plan becomes un-viable, the providers lose income, and many consumers who got care through the pre-payment plan no longer can regularly access care.

There are two possible errors: providing too much care, or providing too little care so that there is a subsequent, large, corrective expense.

Avoiding these two problems requires a core group of clinicians, which can include both physicians and nurse practitioners, who care about being part of the efficient delivery of care. They need to be individuals who are willing to function as part of a *group* with practitioners looking over shoulders of their colleagues, evaluating, commenting, and -- when necessary -- calling their colleagues to task because the interest of the patient is more important than the ego of the clinician.

"Productive management" and "A managing clinician core" are very likely to lead to formal mechanisms being developed which compare, for a given diagnosis, the utilization of resources, and the outcomes realized, for **all** participating clinicians. These devices lead to the disappearance of patterns of practice which are not effective use of resources.

Frequently the solution is to be even more overt: put the clinicians at (some) risk. That is: if the total cost of care is kept at reasonable levels, the clinicians will financially benefit. If the cost of care becomes unreasonable, the clinicians will have a reduced income. Obviously, we are here referring to formal mechanisms for adjusting compensation within a functioning plan. There is the larger, ongoing, participation in being "at risk": if the plan goes bankrupt, it will not pay its clinicians.

E. The prospects for developing pilot pre-paid plans

The Ministry of Health's hospitals in Mandeville and May Pen are appropriate sites for original development of pilot pre-paid plans. They either have, or have the potential of developing, the "Necessary Assets" listed above: An objective, honored care givers, productive management, and a managing clinician core.

They also are Ministry of Health facilities and, as noted earlier (page 12), MoH facilities provide the base which is most likely to provide for replication of a pilot pre-paid plan.

The Chief Executive Officers of both facilities have indicated they are eager to implement pilot pre-payment plans. They feel confident about their ability to successfully bring into the plan a cluster of clinicians who will be honored by consumers and who will function in a thoughtful, cost-effective, manner.

When the question of organizing sales and collection was raised, the two Chief Executive Officers showed flexibility but they had a distinct interest in this being handled directly by the hospitals.

The Chief Executive Officers showed a distinct interest in linking their plans to the Ministry's Primary Health Care service and using incentives (such as co-payments, see page 25) for the use of Primary Care facilities.

1. First Pilots

Therefore, the consultant recommends the first pilot pre-paid plans should be developed at the hospitals in May Pen and Mandeville. Success at these sites would provide experience which would be the base for inaugurating similar plans at other Ministry of Health hospitals.

At the same time, we anticipate Life of Jamaica will continue its efforts in developing relevant health insurance. This includes a recently announced plan in Mandeville which is linked to Hargreaves Memorial Hospital. Thus we have the pleasant prospect of a market in which there are competitive plans being offered. In launching the availability of a new product in a market, the existence of competitive offerings offers the possibility that both plans will do better under direct competition than they might if they were without direct competition; the availability of multiple offerings can act to legitimate the new product.

Additionally, Life of Jamaica is attempting to develop a "Public Hospital Health Plan" which will be aimed directly at the low and middle income markets. This offering will have some obvious advantages using the base of the LoJ company and its many assets. It will also have a competitive disadvantage in the cost of the overhead -- at least 30% of premium -- which LoJ puts into a plan (see page 28). The development of multiple alternative offerings increases the probability of low and middle income Jamaicans getting useful opportunities to level the costs of health care.

These pilots could provide a base which would be applicable to much of Jamaica outside the Kingston Metropolitan Region.

2. Second Pilots

Metropolitan Kingston presents a more complicated situation. The primary governmental in-patient capacity is the Kingston Public Hospital which is still a very troubled facility. At this time it would be unlikely that any members of the public would select membership in a KPH based pre-payment plan.

Because of the size of the region, it is not likely that all the workers at a work site also live in the same neighborhood. This increases the complexity of offering attractive pre-payment schemes which include care giving which is relevant to both residential and work locations.

Hospital costs in Metropolitan Kingston are higher than outside the region. This potentially makes the plans more expensive, and thus, potentially less attractive.

Currently there are at least 39 identified church-based health clinics in the Kingston Metropolitan Region. Collectively, they provide a possible base for developing a pre-payment scheme for low and middle income people in the region. At the moment they are not an adequate formal collective. The InterChurch Association has about half of these clinics as members. InterChurch is still in the process of developing its central secretariat. When the secretariat is functioning and there is experience with pre-payment in more compact and lower-cost communities, it is possible to think of building a pre-payment scheme which is based on services provided through the member clinics of the InterChurch association. In a similar situation in metropolitan Boston, the neighborhood health centers have evolved the Boston Neighborhood Health Plan.

F. A Course Forward

What next? This consultancy has found there is a promising prospect for the development of pilot pre-paid health schemes in Jamaica. What needs to be done to bring those pilots to reality?

1. May and June

Dawn Battick leaves her position as insurance specialist at PSOJ at the end of June. That forms a useful target date: by the end of June we should have in place a plan of action which will lead to the development of pilot plans at Mandeville and May Pen hospitals. That plan would have a reasonably detailed set of steps for implementing and supporting the inauguration of the pilot pre-payment plans.

The Mandeville and May Pen hospitals have already agreed to gather information which provides an enhanced perspective on their current financial activity for providing care. This will be of importance in developing the expected costs of care and the expected premium to be charged. They are gathering this information for consideration by the end of the third week of May.

A major part of the activity would be working with these hospitals. This would include carefully working through the details of the design of the proposed pre-payment plans, and developing a plan for the staff, other resources, and activity necessary to implement and operate the plan. This would include development of month-by-month budgets and projections of cash flow.

One component of the plan of action would be the specifications for any contracts which are seen as necessary to assist in the start of the plans. At the moment, two contracts are seen as necessary:

- Development of the Information System. A contractor would work within the framework of an off-the-shelf spreadsheet or database program and would create a package of forms, macros, and files which would support all the information needs of the plans. This would include: enrollment, revenue management, and tracking of utilization (at least by the individual, by the practitioner, and by the contract form).

- Development of the Marketing Campaign. A contractor would work with the plans to develop their marketing campaign, including the materials to be used, and would train the sales staff.

An effort would be made to explicitly identify all the money needed to support this effort. This will include identifying what kinds of financial support are necessary, and, where possible, how that money will be provided. Assuming the pilot plans are successful, it is anticipated relatively little financial assistance will be necessary for future pre-paid plans to develop. Given the uncertainty that comes from lack of experience, we are attempting to reduce the probability of non-success by committing resources to the initial two pilot plans.

The resources needed will likely be for:

- Funding the initial contracts as noted above. The investment in programming the information system will be an asset which can be available to other new plans.
- Provision of ongoing technical support. This effort will involve regular support to the plans which will both assist them and will attempt to document the development of the plans so as to create a base for the development of other plans. This will involve the position of the Insurance Specialist at PSOJ and an external technical assistance consultant.
- Possible funding for some initial operating expenses. This might include the cost for the first two months of staff who are explicitly added to market the plan. After that time it is assumed the plan will be able to pay their salaries.
- Possible funding for some initial capital expenses. The likely capital will be a Computer(s) for each site and the purchase cost of the spreadsheet or database program in which the information system is developed.
- A separate type of resource could be useful: a "guarantee fund" which would underwrite any losses during the initial period of offering the plan.

A "guarantee fund" could be aside from the initial operating and capital expenditures enumerated above. In this case, the possible "loss" would be quite unlikely.

Alternatively, the "guarantee fund" could also be the device for the initial operating and capital expenditures.

In a similar development in the Philippines, US AID's PROFIT project is providing a cash advance equal to the projected net loss in the first three years of the operation of that plan. The projected loss is about \$150,000. If the plan develops successfully, this advance will be repaid with 50% of profits developed by the plan up to the amount of the cash advance actually used.

PROFIT has previously shown interest in health insurance in Jamaica. They may be interested in participating in the development of this scheme.

PROFIT is a project of the AID Office of Population; in Jamaica, the family planning and maternal and child health benefits which PROFIT would like to see in a plan are implicit in the services of the Ministry of Health.

This effort will involve the consultant for a period 21 working days, including one 6 day work-week, starting with the week of the 30th of May. It will involve about 7 days of preparatory work. Then there will be a trip to Jamaica of about a week and a half in length, and a final week after that trip to complete assembling the materials and the report.

2. Subsequently

With a plan of action fully developed by the end of June, in July the implementation of that development plan will begin.

Annexed Material

A. Issues in Design

There are, literally, hundreds of different dimensions on which pre-paid health care plans can vary.

Earlier in this report are four very important dimensions are listed: having a clear objective, being an honored care giver, having productive management, and having a managing clinician core.

There are a number of other dimensions. Our effort here is to bring together as many dimensions as is possible in a single item to keep the list short. Our second effort is to assure we have sketched all critical issues which could bear upon the success of a proposed effort in pre-paying for health services.

This list is intended to allow the executives of the prospective pilot plans to think through these design issues during May; the list will be used as the basis for the development of the specific design of the pilot pre-paid plans during the month of June 1994.

1. MoH Non-Decentralization

Autonomy of the core organization is important for the success of a pre-paid plan. The organization must have the ability to make and honor commitments on a timely basis and to adjust to local realities among those who provide care and among those who buy care.

Such autonomy is not a routine characteristic of Ministry of Health capabilities in Jamaica. The formal effort to realize a "decentralization" of power from the central offices of the Ministry of Health has many times led to disappointment.

Most of the progress made in improving Ministry of Health services has been made because of the risk taking, extra-legal, behavior of many of the managers and executives who are tucked away in the service of the Ministry. Virtually nothing is accomplished by following the formal dictates of the Ministry (or its rigid sisters such as the Ministry of Finance and the Ministry of Public Service).

The continued failure of the Ministry of Health to effect decentralization leaves those who are interested in dramatically improving the Ministry's service in a difficult position. Effectively, they are pursuing activities which are, charitably, "extra-legal". They run the risk that someone aggrieved will punish their initiative by finding a way to classify their activity as not "extra-" but "il-" legal.

Optimally, these hospitals would have been devolved to the authority of diverse boards with deep local roots which view these hospitals as being

"public" not in the sense of being "Ministry of Health" but in the sense of being a treasure which must well serve their local community.

In the meantime, there is a choice: wait for decentralization to occur before starting to attempt the initiatives that should then occur, or, pursue those necessary initiatives without decentralization, despite the hazards of such extra-legal action.

The wide variety of people we have consulted have all believed it is necessary to go ahead with initiatives like pre-paid care for low and middle income individuals despite the lack of facilitating action by the Ministry. Hopefully, after such efforts are successful, the Ministry will, after-the-fact, legitimate the actions taken as a mark of respect for those who took risks in pursuing important social goals.

2. Equity

Conceptually, and possibly legally, there are some major questions of social equity which are raised by the thought of a pre-paid health care plan aimed at the low and middle income populations.

a) Paying Twice

Jamaica has already evolved a device for paying for health services. It involves payment on the basis of ability, and provision of services on the basis on need. The system is called taxation. In the 1990s it is not working.

Pursuit of this system has had a net effect which is contrary to its intent. The result of the current hospital system is "An informal health insurance scheme, subsidized by government, [which] heavily favors middle and upper income Jamaicans, severely limits access [by] poor patients, and largely excludes Jamaican private practitioners from MoH hospitals.⁹"

When you approach a Jamaican citizen and propose they should pay a monthly premium to a healthcare pre-payment plan, the citizen can appropriately ask "What is this? I already paid with my taxes!" That allusion may continue in Jamaican law and in some political discourse.

Observers seem to agree: the bulk of Jamaican people understand dependence on taxes to finance health care can offer little; they understand the health services they want to have available must be paid for out of the pockets of citizens *after* they have paid their taxes.

Yet, the image of "equity" and of "paying twice" will continue to be a reality that those involved in developing pre-paid health care schemes must anticipate.

⁹ Boston University Center for International Health, "Preliminary Report: Jamaican Health Sector Expenditure-Based Analysis," Preliminary Report, 16 February 1994, Sheet 51.

b) A dis-equitable system

What about the poor? What will a "pre-payment" health plan aimed at low and middle income populations do for the poor?

Something; not much, but something.

Those who have insufficient resources, (frequently because they are unemployed, or in family units that lack sufficient employed persons) will not directly get health care from a pre-payment scheme. A basic assumption of such a voluntary scheme is that the participants will have equal entitlement to benefits for equal premium. Thus, while much of society may gain, those with no income, or very low incomes will not directly gain.

One of those we consulted was concerned about the ability of those who are employed, and still are very poor, to pay for the cost of care. He proposed: "Why not charge premium as a percentage of income?" This would protect the very low income person. For a plan to be viable under those conditions would require that an appropriate portion of people with higher incomes also pay a premium on the basis of a percentage of income. Those people, of course, would have a lower premium for the same benefits in a "level premium" plan; we can assume they would move to the competing coverage. The "percentage of income" scheme is only likely to work if competition is legally barred and participation is mandated; that is, effectively, a tax based system.

Yet, the very poor *will* gain from a pre-payment scheme. If such schemes move more money through Ministry of Health facilities, those facilities will provide better service. And, when the very poor go to those facilities and are unable to even make the requested co-payment, they will get better care than they would if there was not the pre-payment plan putting money into the Ministry of Health.

3. Physician affiliation

Two of the four items in the list of prerequisites were: "Honored care givers" and "A managing clinician core." The importance of these prerequisites is reinforced by putting on this list of design issues the question of "physician affiliation and management."

In any setting, it helps that the public thinks well of the possible inpatient facility to which they might be admitted once every ten years, on average. What is crucial is what the public thinks of the clinicians they will be seeing, on an ambulatory basis, on average, twice a year.

While the "clinicians" who are involved may include nurse practitioners, in most settings, public confidence is built around the reputation of the physicians who are on the list.

In some settings, the name of a creditable organisation and the assertion that the physicians are licensed is sufficient. A number of our contacts have emphasized the importance of physician identity in Jamaica. The figures we have seen for the revenues of private physicians in Jamaica,

exceeding one half of all health care expenditures, indicates the credibility of individual physicians is potentially the most distinguishing part of the Jamaican health economy when compared to world norms.

In any case, when people are already committed to the use of a particular doctor, it is difficult to sell them a pre-paid plan unless it specifically includes "their" doctor. In the Philippines it is possible to go to market with a pre-paid plan without citing doctors by name. In Jamaica, this may not be possible.

Rather, in Jamaica, it appears more important than elsewhere to include on the panel of available physicians those who are already revered by the community. Individual members of a pre-payment scheme may join the scheme because of the availability of an individual physician, even though they may not actually push to be sure that physician is their source of primary care.

Careful attention will have to be provided to the choice between increased cost, and increased creditability from the inclusion of "name" physicians on the list of those who are available to provide basic care encounters.

4. Physician Management

Physician Affiliation appears crucial, especially at initial sales, in Jamaica. Physician Management is especially crucial in the longer run in the success of a pre-payment plan.

We are talking about the management of the practice behavior of *clinicians*; but the label on this section only refers to *physicians*. This overt narrowing to physicians is in recognition that there is no recorded problem of getting nurse practitioners to subject themselves to collective discipline. There can be a problem with physicians.

Originally, a pre-paid plan may fare well without a formal discipline among its clinicians (effectively, among its physicians). In the longer run, plans will experience competition. Those that lack a collective sense of concern, focus, discipline and management will not be survivors in a competitive environment. Inaugurating such collective managerial behavior after mortal competition becomes obvious is likely to be too late.

Prudently, a pre-paid group of physicians should formally inaugurate devices for regularly monitoring the character and results of their practice. This is generically useful and of special benefit in providing care which attempts to be cost-effective and competitive. At times this runs contrary to the individualistic bent of some practicing physicians.

5. Maintaining consumer confidence

To enroll consumers in a pre-paid plan will require the existence in the consumers of a level of confidence in the plan and the care givers. To keep people enrolled will require maintaining that consumer confidence.

A portion of this is fulfilled by having formal devices for overseeing the clinical practice. That will not be enough. The offering agency needs to have an ongoing, aggressive sense which leads it to be in contact with its customers. The result will be to find opportunities for cost-effectively improving the level of consumer satisfaction, and for discovering issues which are about to mature into real problems.

6. Benefit Structure

The benefits are what people are buying. If they are not attractive, for the price, they won't buy.

a) Strategy of expansion of benefits

As the pre-payment plan succeeds in the marketplace, it may change. A likely path is to initially offer a limited set of benefits; subsequently, with more experience (and thus more confidence), additional benefits may be offered for the same price, or at the time of an increase in premiums.

That growth path needs prior inspection. To the degree that it is possible, it is useful to offer a "full" set of benefits from the start, this maximizes the probability the initial offering will be successful.

In starting a plan you can err in two directions. On one side you can offer a very limited set of benefits and run the risk of the plan being uninteresting and therefore having it fail in the market. On the other hand you could offer a very wide set of benefits, without sufficient base of knowledge, and the plan could be very popular but the benefits could cost too much for the premium income.

b) Exclusion periods: Group vs. Individual Enrollment

When you are enrolling members through a group, the primary reason for people to sign up is that they are employed; the availability of your pre-payment plan is secondary. In individual enrollment you risk getting a disproportionate number of individuals who have major health problems; this "adverse selection" is a risk that is reduced in group enrollment.

One protection against "adverse selection" is to have exclusion periods. Any condition which exists at the time of enrollment will not be treated for a period of time. Commonly, exclusion periods are used for non-group (voluntary) individual or family enrollment; they are seen as less necessary when coverage is provided on a group basis.

The Doctor's Community Health Plan, as offered in Montego Bay by Life of Jamaica, has an exclusion period for group members who are originally enrolling.¹⁰

¹⁰ "Waiting Period for Pre-Existing Conditions: No surgical benefit, hospital care or maternity allowance will be provided for any medical condition (including pregnancy) that exists on the date the plan becomes effective, until a period of 9 months of continuous membership in the plan has expired. The 9-month waiting period will also apply to new members joining the plan after the effective date. Waiver: This condition is waived in respect of any company whose enrolled employees

c) Co-payment and deductibility

Frequently plans have some form of cost-sharing with the participants. In indemnity plans a *deductible* represents the amount of bills the plan member must pay before there are benefits. In "major medical" coverage this could be a "high deductible" that might exclude the first \$10,000 or even \$50,000 of coverage in a year. The coverage that is then provided is real "insurance" in being for a rare, but expensive, event.

A deductible would be unusual in a pre-paid plan aimed at low-income people. The point of the plan is to give them protection from substantial out-of-pocket costs when there is illness or injury.

Co-payment could be a feature of a pre-paid plan aimed at low and middle income consumers. In theory a co-payment reduces the "moral risk" that someone will use care because they are enrolled in the plan that they would not use if they were not in the plan. In a pre-paid plan that is not a great "risk" because, other than the patient making an ambulatory visit, all other services are only available because they are ordered or prescribed by the plan's clinicians. "Over use" can be considered a medical condition, hypochondriasis, that needs treatment.

The current *entitlement* of citizens of Jamaica for services of the Ministry of Health hospitals includes the expectation of paying a co-payment fee, unless exempted by an assessment officer. If the co-payment required by a pre-paid plan is equal to, or larger than, the co-payment currently required by a Government of Jamaica service, a consumer could wonder what benefit they are getting from the pre-paid plan.

Co-payment can be used to steer patients. For instance, when co-payment fees become required of a patient attending a curative primary health care visit, it would be possible to arrange to have no co-payment required of members of the pre-paid plan. At the same time, the members of the plan might be required to pay some co-payment if they chose to go to a hospital out-patient department instead of the primary care center, but that co-payment would be lower than the co-payment required of any public patient who did not have membership in the pre-payment plan.

A second form of co-payment is in *limits* on the amount covered. This is common in indemnity insurance plans; they may limit their payments for hospitalization to some maximum number of dollars per day. Anything above that figure would be the responsibility of the patient. Such limits are found in the Montego Bay Doctor's Community Health Plan.

These limits are particularly of use when the core organization which provides the plan is not providing the care or managing the provision of the care. When the core organization which provides the plan is also directly providing or managing the care, there is little need for this protection of the plan. To a degree, the point of the plan is to avoid such limits.

(and enrolled dependents) were continuously covered under any other insured group medical plan which is replaced by this plan to the extent of such coverage or to coverage under this plan whichever is the lesser." From the LoJ presentation of the Doctor's Community Health Plan.

d) Drugs

In many settings, provision of drugs is one of the last benefits to be added to a plan. In Jamaica, the cost of drugs is a major issue. The Doctor's Community Health Plan in Montego Bay has a majority of its benefits being taken in the form of drugs; drugs cost more than the combined cost of doctors and hospitalization. That plan provides prescription drugs, injections and medications prescribed by the plan physicians for specialists to whom they have made a referral; the member pays J\$ 20 per item or J\$ 40 per item for maintenance drugs if supplied by Doctor's Hospital, otherwise, if supplied at a cooperating pharmacy, the member pays 40% of the retail cost.

It is obvious a drug benefit would be an important component of a plan in Jamaica. It is also obvious that the drug benefit needs to be carefully designed to both serve the patients well and to protect the integrity of the plan.

The key for Ministry of Health facilities would be the implementation of a variety of schemes which should both lower the cost of drugs to the Ministry and increase the certainty of supply.

e) Out of area emergency care

When the basic care benefit is rooted in a specific care site, consumers will, wisely, ask: "what if I have an emergency elsewhere?" One option would be to provide no such benefit: citizens of Jamaica are eligible for care in Government Emergency Rooms.

Another option would be to arrange with specific other hospitals in Jamaica for care. The Doctor's Community Health Plan has arrangements for care at four hospitals¹¹ out of the Montego Bay area.

f) Out of country care.

A much larger issue is out-of-country-care. Care can cost much more out of Jamaica! It seems unnecessary to include this feature in a plan targeted at low and middle income consumers in Jamaica. Those able to afford international travel can explore securing appropriate insurance to cover them while traveling.

g) Optical services and devices.

Appropriately, professional eye care is frequently included as a basic service. To include this service will require assuring the care givers have the capability, or by making a special contractual arrangement. If professional eye services are to be provided through contract, a higher co-payment might be required for such a visit. This is found in the Doctors' Community Health Plan in Montego Bay.

¹¹ At Nuttall Memorial Hospital, Kingston; Ocho Rios Medical Centre, Pineapple Place; Hargreaves Memorial Hospital, Mandeville; St. Ann's Bay Hospital, St. Ann.

The Montego Bay plan also includes a benefit for spectacles. The frames must be chosen from a utilitarian line (not high priced) of frames; the member pays J\$ 300 per pair and is eligible for one pair every 2 calendar years. This benefit is considered popular with some employers because there were employees who were effectively visually handicapped on the job without the benefit.

h) Maternity Benefit

Some plans specifically state they do have a maternity benefit, as aside from other care. Specifically stating the maternity benefit is a device for enumerating special conditions, such as "Plan pays \$..." and for noting there is no maternity benefit for 9 months after enrollment.

A strong argument can be made for avoiding such specific limits and including Maternity related benefits as part of the ordinary process of giving care. Indeed, when there is some co-payment for curative visits, there could be a lower co-payment for non-curative maternal and child health visits.

7. An enrollment fee

An enrollment fee is paid at the start of enrollment in the plan. Enrollment fees are unusual in group policies.

For enrolling people on an open, non-group, basis, it is possible to include an enrollment fee; frequently an enrollment fee is approximately equivalent to one month's premium. Thus, at enrollment, the equivalent of two months of premium needs to be collected.

Collecting an enrollment fee matches revenues to costs. There are special costs involved in starting enrollment in a plan: the cost of the sale of the plan, the cost of membership materials and credentials, and the cost of inaugurating membership records. By collecting revenue to match these costs at onset you are able to offer a lower monthly cost.

An enrollment fee can also act as a device to assist in collecting periodic payments to the plan. With no enrollment fee, one may choose to skip paying for one month, and avoid seeking care during that time, and then re-enroll in the following month and seek care at that time. If there is an enrollment fee, the price of this tactic is raised.

8. Sales and Collection

Somebody needs to sell the plan, enroll the members, and collect the money. Here the difference between group and open enrollment sales becomes important. Group sales are relatively efficient, and the collection of premium for a group involves only one check a month.

For open enrollment, sales involves work with families and individuals, and collection involves collection from each family; this is a substantially greater burden.

The Doctor's Community Health Plan in Montego Bay has its sales and collection done by Life of Jamaica. Although there are some variances in past agreements, Life of Jamaica now will undertake this task for a plan for 30% of the amount of premium collected. This is for *group* sales and collection. Thus, for every dollar of premium paid, 30 cents goes to LoJ and 70 cents goes to the care giving process.

Stated otherwise, to get 70 cents of care, you must pay a sales and collection charge of 30 cents, that is a 43% "mark-up" ($0.3 / 0.7 = 0.43$) for sales and collection to employee groups. This may accurately reflect LoJ's current overheads. By international standards, this 43% mark-up is quite high.

Elsewhere, with focused health plans (such as the Doctor's Community Health Plan) under group enrollment, insurers have been able to achieve the sales, collection, and payment functions for 10% or less of total premiums collected. Ten cents for sales and collection and 90 cents for care gives a mark-up of 11% ($0.1 / 0.9 = 0.11$). There is a substantial difference between 11% mark-up and 43% mark-up.

But, if the plan isn't sold, and the income is not collected, there is no plan! Thus, getting effective sales and collection at a reasonable cost is of substantial importance.

Mandeville and May Pen hospitals have indicated interest in directly undertaking this effort. This would exploit the positive relationships the hospitals are developing with their communities. It would also add to their managerial burden. A number of alternative devices are possible.

9. An intermediary

"Intermediary" is a term, in health insurance, which evolved in the United States under the Medicare program. It referred to the agent, frequently a Blue Cross Plan, who processed and paid the indemnity claims from the cash they were, periodically, given by the U.S. Government.

With a service (rather than indemnity) plan there is not a great need for an intermediary of this type. However, there is a meaningful other sense in which "an intermediary" can be considered. This is the "ownership" (and direct management) of the funds of the pre-payment plan. These funds could be directly managed by the two hospitals in the pilots. Alternatively, a non-profit agency such as the PSOJ might serve as the custodian of the funds. Deposits would be made to a PSOJ account and disbursements would be made as directed by the hospitals that were actually implementing the plans. The merits of such an intermediary relationship need to be further explored.

10. Adverse Selection

Adverse selection involves getting into the plan a population which is sicker than the general population. It is especially a concern in non-group enrollment processes. Devices for controlling adverse selection have been discussed under other headings.

11. Moral Hazard

Moral hazard is the risk of people, once enrolled, to behave in such a way as to increase their need for care. Moral hazard, in the sense of self-referral to specialists, is a problem in indemnity plans. As noted earlier, under the envisioned pre-payment scheme which provides direct service, the consumer only has a "right" to ambulatory visits. All other uses of care are determined by the clinicians.

The only sense in which there is a residual "moral hazard" is in the probability of people choosing to engage in self destructive behavior with the pre-paid plan which they would not engage in without the plan. There does not seem to be a substantial probability of people starting to smoke because they have joined a pre-paid service plan.

12. Graded Products

There can be *a plan* or there can be *plans* at a given site. The Doctor's Community Health Plan in Montego Bay actually offers three grades of Plan: Plans I, II, and III. The premiums and the benefits go up with the increase in the number of the plan.

Providing graded products can add complexity, and even confusion, to managing the scheme. However, having graded products can increase the ease of sales of the plan because it is more likely that individual consumers will find a product that exactly meets their needs.

13. Units of Enrollment

A plan, whether sold to groups or through non-group enrollment, will obviously enroll individuals.

How will it enroll families? Are families just collections of individuals so that a 5 member family is five individual enrollments? On the other extreme, there could be one "family" unit of enrollment, with a stated monthly premium; the same cost would be faced by a married couple who had not started a family as would be faced by a couple with a substantial number of children. Generally, after the first few years of life, children and young adults use less care than older adults. It is possible to view, as a possible expense, the cost of more than one child as being equivalent to the cost of one adult.

14. Premium Cycle

Frequently the cycle for collection of premium is the month. Payments are due before the start of the month.

However, the dominating features of the local economy can lead to alternative cycles. In service to agricultural communities, it may be better to collect premiums at the end of each harvest for a period which runs through the next harvest.

15. Fraud

Fraud is a concern in every contractual relationship. It must be kept in mind in designing pre-paid health plans.

A particularly troubling form of fraud is related to the issue (above) of "units of enrollment." If allowed to do so, a family may enroll only some of its children and then will bring in other children, of similar sex and age, for care using the name of those who are enrolled. The great risk here is of harm to the child when they are given care based on what has previously been recorded for the health history of another person. This fraud can be avoided by requiring the *entire* family be enrolled.

More difficult is the substitution of cousins or neighbor children who are similar in sex and age. One solution to this is to overtly spend the money necessary to provide photo identification credentials and to periodically take new photographs of children to reflect their growth.

16. Inflation and Devaluation

While Jamaica has, in the last year, seen its currency move from 22 for one US\$ to 33 for one US\$, overall, Jamaica's currency is not highly unstable. In other settings, where there is hyper-inflation, it can become necessary to change the premiums required every month (alternatively: to state the premium amount in terms of a stable currency). This is unlikely to be needed in Jamaica.

Jamaica enjoys apparent high real rates of interest on sizable bank deposits. To the degree that pre-payment can create more working capital than is necessary, a plan in Jamaica could invest its surplus funds at a rate which both accommodated for inflation and provided additional funds through the interest paid which is beyond inflation.

In situations, such as Zaire where there is hyper-inflation and harvest-based premium cycles, it is mandatory to have a careful strategy of managing premiums to assure maintenance of their buying power.

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C. Schedule

Monday 18 April

- 10am Dawn Battick at PSOJ.
Initial meeting (beyond phone conversations). Review of PSOJ programme within HSIP. Review of schedule for the week. Learn of Dawn's resignation effective at the end of June.
- 11am David Taylor at PAHO, with Dawn Battick.
Emphasis on Jamaican's valuing of Private Practitioner services; introduction to value of data conducted by Boston University CIH staff. Questions of Means Test exemption -- equity -- ability to implement a pilot. Avoiding "National Insurance". Review of status of MoH decentralization.
- 2pm Dr. Holding-Cobham and HSIP Senior Staff, with Dawn Battick
Importance of contacting Dr. Horace Chang in Montego Bay. Means for embracing younger practitioners. Cyclical payments out of Christmas bonus. Covering Drug expense. Risk of Fraud. Possible use of Co-ops for enrollment.
- 3:30pm At US AID with Betsy Brown and Cheryl Davis-Ivey
Possible voluntary agencies who could be sales agents. Development of primary care fees. Furnished copies of some Boston University CIH data. Review of current status of decentralization of MoH and the environment for change. Discussion of consultant commitment for ongoing oversight of pilots.

Tuesday, 19 April

- 9am Paul Sharp, Life of Jamaica, with Dawn Battick.
Company history in starting HMO offerings. Proposed new developments. Recruiting physician support. Target: 30% of premium into group sales and collection. Detailed view of current scheme(s) in Montego Bay. History of other HMO plans. Appointment terminated early due to priority request from company president; follow-up session scheduled.
- 11am Via Telephone with Dr. Diana Ashley, Principal Medical Officer (Secondary & Tertiary Health Care), Ministry of Health. Discussion of concept and potential benefits. Review of history of discussions with potential industrial customers and possible industrial marketing opportunities. Importance of differentiating product. Prospect for MoH decentralization. Magnitude of drug expenses and prospects for reduction. Integration of PHC in schemes.
- 2pm At May Pen Hospital: meet with May Pen CEO, Lorna Salmon-Baker and Mandeville Hospital CEO, Joy Webley; joined by Dr. Robinson, Clarendon PHC Officer; with Dawn Battick. Interest in a pre-payment scheme. Preference to use the Hospitals as the base for a scheme. Verification of current rough cost estimates. Confidence in ability of Hospitals to forge relationships with physicians. Concern over drug

supplies. Sales devices including use of old employees. Conversion of Hospital Employees to scheme. Arrangements for segregation of funds. Management of practice behavior; use of comparative practice profiles. Integrating with Primary Health Care. Relevant operating data and expanded budgets to be available by end of third week of May.

Wednesday, 20 April

9am At PSOJ, Fay Petgrave, former Blue Cross employee familiar with issues in development of health insurance; with Dawn Battick. Exploration of a wide range of possible problems in the development of a pre-payment scheme. Need for clear specification of desired outcomes with clear measurements. "Doctor orientation" in Jamaica. Comparison of virtue of adding complicated features to the scheme from the start versus adding at a later date.

10am At PSOJ, Dr. Alfia Samuels, Medical Officer overseeing Primary Health Care in metropolitan Kingston, and private practitioner; with Dawn Battick. Current status of fee collection for primary care; prospective future arrangements. The "Clarendon solution" for integration of PHC into a pre-payment scheme. Consideration of integrating notable physicians into the scheme by allowing them to encounter patients in their own offices; value of this feature in selling the plan. Need for limits on drug benefits.

12 noon Telephone conversation with Dr. Horace Chang, principal of the Doctor's Community Health Plan in Montego Bay. History, features, strengths, and future plans for each of three operating alternative schemes. Drug benefits; efforts to reduce cost. Relationship with LOJ for sales and collection. Core managerial attitude necessary for success. Integration of private practice sites. Operations of the optical service and dispensing benefit. Prospect for a dental plan.

2pm At PSOJ - Mr. Leslie Chang, Managing Director of British Caribbean Insurance. (He was unable to arrive prior to the start of the 3pm meeting.)

3pm At PSOJ: PSOJ's HSIP Project "Technical Evaluation Panel". Holmberg participates as a guest; about 40 minutes of discussion of the objects, methods, and expected products of the consultancy. Exploration of issues of development of community confidence.

Thursday, 21 April

10am At PSOJ: PSOJ Executive Director, Mr. Ross. (Appointment cancelled due to illness of his son).

11am At PSOJ: Rev. Stanley Clarke and Dr. Gregory of the InterChurch Association, with Dawn Battick. Exploration of impact of proposed pre-payment on very low income employed individuals. Consideration of plans with premiums set as a proportion of income. Review of fees in existing clinic services. Discussion of use of the InterChurch Secretariat as a device for offering a network of care centers in

Metropolitan Kingston; consideration of the timing of such a development and the timing of development of the Secretariat.

2pm At Bustmante Hospital for Children with CEO Mrs. Nugent, with Dawn Battick. Exploration of this specialty hospital being the base for a family health scheme. Discussion of possible sites for identifying possible clients for plans. Consideration of data requirements for pricing family plans.

5pm At Pegasus Hotel, second meeting with Paul Sharp of Life of Jamaica, with Dawn Battick. Further exploration of the cost of using LOJ as a marketing and collection agent. A broad discussion of possible design features of low cost plans embracing both the work of Holmberg and Battick and the work going on at LOJ toward the development of a "Public Hospital Health Plan."

Friday, 22 April

10am At US AID Kingston, end of visit debrief with Betsy Brown, with Dawn Battick.

Hmqt

**DRAFT SCOPE OF WORK
FOLLOW-UP ASSIGNMENT**

SCOPE OF WORK
LAC Health and Nutrition Sustainability (LAC HNS)

JAMAICA TSO #25: INTERNATIONAL TECHNICAL ASSISTANCE TO HSIP
Technical Assistance to PSOJ for Low-Income Insurance

Component: Private Sector Organization of Jamaica (PSOJ)
Component Head: Dawn Battick PSOJ

Consultant: Hopkins Holmberg
Total Level of Effort: 12 days (3 days preparation, 5 days in Jamaica, 4 days report writing/analysis and travel)
Timing of Services: May 24 - June 30, 1994
Travel: 1 RT Jamaica
Contractor/Charge No.: ISTI/276-083
Source of Funding: USAID/Jamaica Buy-in/TSO #25

PURPOSE OF CONSULTANCY

The consultant will provide follow-on technical assistance to assist the PSOJ to develop a viable scheme of pre-payment for health care which focuses on low and middle-income populations. During this phase, the consultant will further develop a proposal for a pre-payment health care plan based in two pilot public hospitals. It is anticipated that future assignments will involve further development of the business plan, as well as the provision of technical assistance for training and start-up implementation of the insurance program.

SPECIFIC ACTIVITIES

1. Prior to departure to Jamaica, the consultant will review and analyze financial data to be provided by the potential pilot sites for the pre-payment insurance plan--Mandeville and May Pen Hospitals. This data will be incorporated into the cost structure of the proposed pre-payment insurance plan being developed by the consultant. The consultant will also discuss management and financing issues related to the program with PSOJ insurance specialist Dawn Battick and LAC HNS staff in order to further detail alternatives to be explored during the field visit. Based on these discussions and the findings from the previous visit, the consultant will coordinate with Dawn Battick to arrange site visits and meetings in Jamaica.
2. During the field visit, the consultant will work with Dawn Battick, staff from the pilot hospitals and other appropriate contacts to design an operating plan, which will involve the identification of staff and other resource needs. Based on this plan, the consultant will work with these counterparts to develop an estimate of the cost of the pre-payment package. The estimate should include the expected cost of clinical services as well as operating costs such as administration, management, and marketing. As in earlier estimates, program costs should be illustrated on a per client basis in order to develop estimates of the feasible range of premiums

to be charged. Costs and premiums for both public and "private" patients should be developed. Using operating cost estimates and revenue projections, the consultant and the pilot hospital staff will draft month-by-month budgets and cash flow projections for the program's operation.

Options for the financial management of the pre-payment program, including the establishment of a trust or alternative non-profit entity, should be identified as part of the operating plan.

3. Drawing on the financial data developed in (2) above, the consultant will attempt to identify the financing needed to initiate the pilot programs. A draft proposal to the PSOJ for start-up operating and capital costs should be prepared as part of the consultant's final report. The proposal should identify one-time start-up costs such as training and equipment (e.g. computers), as well as initial operating costs that would not be covered by premium payments. As noted in the consultant's previous report, the concept of a guarantee fund to underwrite losses during the initial offering should be explored with the PSOJ and AID. In addition to the PSOJ, alternative investors/sources of start-up funding should be identified (possibly PROFIT).

4. The consultant will meet with MOH staff (including, if possible, Dr. Deanna Ashley) and other appropriate contacts suggested by PSOJ, HSIP and USAID staff to introduce the concept of the pre-payment plan and receive feedback on the proposal.

5. The consultant will submit a final report to LAC HNS no later than two weeks after departure from Jamaica. The report should outline the proposed benefits structure, premium rates, and marketing/operating plan in as much detail as is feasible. In addition, the report should reassess the likely success of the plan based on progress to date, and provide recommendations for follow-on steps, including developing an information system and marketing campaign plan as noted in the previous report.

RELATIONSHIPS AND RESPONSIBILITIES

The consultant is to work under the supervision of Dr. Thomas Bossert or Michelle Mendez, LAC HNS Project, and Betsy Brown, HPN Officer, USAID/Kingston. In all activities the consultant will work with PSOJ counterpart Dawn Battick.

The consultant will meet with Betsy Brown and Dawn Battick on arrival, and present a brief report during debriefings with USAID and PSOJ prior to departure from the country. The consultant should discuss the proposal with Dr. Marjorie Holding-Cobham of the HSIP.

DELIVERABLES

A brief outline of the report defined above, including recommendations for follow-up activities, to be presented to and discussed with PSOJ, HSIP and USAID/Jamaica prior to departure.

A final report (including a trip report) sent to LAC HNS no later than two weeks after departure from Jamaica. As in the consultant's previous report, assumptions utilized in developing cost estimates (e.g. the size and nature of the target client population; services/benefits to be provided; staffing needs) should be detailed to allow for review by appropriate local counterparts.