

COST RECOVERY IN JAMAICAN HEALTH FACILITIES

FINAL REPORT

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EXECUTIVE SUMMARY

The purpose of this consultancy for Jamaica's Health Sector Initiatives Project was to assist the Jamaican Ministry of Health (MOH) to develop an appropriate fee schedule for public sector hospitals. Fiscal pressures have limited the central government's ability to provide support for the health sector which in 1992 totalled J\$ 880 million (US\$ 40 million)¹, or the equivalent of US\$ 17.75 per capita.

This government budgetary support, however is insufficient to support the public health sector. In order to raise additional revenues to improve quality, compensate for underfinancing, and pay the additional recurrent costs of projects underway, the MOH would need additional annual revenues (in 1992 prices) of J\$ 363 million (US\$ 17 million), or US\$ 6.60 per capita. This represents 37% of the current MOH budget. The author proposes a fee schedule that is designed to generate approximately this level of revenues.

The proposed fee schedule would be based on three economic tiers:

- Indigent patients (the lowest 20% of patients in income) will pay no fees;
- Public patients (the middle 55% of income) will pay modest fees, though higher than current levels
- Private patients (25% of patients with higher income or private insurance) will pay substantially higher fees.

For inpatients, patients will pay a fee for hospital services based on estimated costs of the expected length of stay for their admission, the type of hospital service (medicine, surgery, or obstetrics) and the expected length of stay. This system is similar in principle to the Diagnostic Related Groups (DRGs) used by Medicare in the U.S. Drug costs will not be included in the fees, rather they will be sold separately. For an average (6-day) medical admission, for example, the proposed public fee would be J\$ 180 (US\$ 8) and the proposed private fee would be J\$ 2,200 (US\$ 100). Compared to the present 1% cost recovery, the proposed system will cover 32% of costs overall of an average medical admission. Rates of cost recovery vary substantially by economic tier--being none of costs for indigent patients, 21% of costs for public patients, and 84% for private patients, Most (65%) of the revenue would come from private patients, with the balance (35%) from public patients. Ambulatory fees would range from J\$ 30 (US\$ 1.36) in public clinics to J\$ 150 (US\$ 6.82) in a private session.

While all patients will receive adequate and medically sound services, in order to justify the higher fees private patients will enjoy prompter admission, more convenient hours, greater

¹Net real support: MOH budget less "grants in aid".

comfort, more attractive settings, and greater privacy. The attractiveness of these services can allow the government to increase revenue substantially with only modest increases in public fees. The success of these recommendations depends on improving the quality and organization of services. To assure this, the author recommends training, decentralized decisions, private management of private services, incentives for health personnel, and regular monitoring of the effect of user fees.

The author recommends that hospital fees (both inpatient and outpatient) be implemented before the establishment of fees for primary care facilities. These fees should be proposed based on an analysis of costs of ambulatory services in health centers.

INTRODUCTION

This report is the summary of a technical assistance assignment (Jamaica TSO #16) provided to the Health Sector Initiatives Project (HSIP) through the Latin America and the Caribbean Health and Nutrition Sustainability Project. To assist the cost recovery component of that project, the purpose of this assignment was to support the Ministry of Health (MOH) objective of fee revenues covering 20% of recurrent costs. Two specific activities were requested: (a) to review background studies on hospital costs by another consultant (Prof. George Cumper), data from the Living Standards Measurement Survey, and other relevant information; and (b) to recommend, if possible, a consensus proposal on fee options for the MOH.

This report is based on a one-week trip to Jamaica (October 4-9, 1992) and subsequent telephone discussions. Seven working days were authorized for this task -- five in Jamaica and the remainder for preparing the report. The consultation was guided principally by Dr. Christine Moody (HSIP), Ms. Betsy Brown (USAID/Kingston), and Dr. Thomas Bossert (Health Nutrition Sustainability). This consultation concluded with a presentation on October 9, 1992, coordinated with Prof. George Cumper to senior officials of the Ministry of Health chaired by Mrs. Keating (permanent secretary) and Dr Barry Wint (Chief Medical Officer). This report documents the items presented in that briefing, with some revisions and additions based on initial comments and telephone conversations.

(Note: The current approximate exchange rate, used in this report, is 22 Jamaican dollars (J\$) equals one United States dollar.)

Part I: LEVEL OF USER FEES

To determine the recommended level of user fees, we must first estimate the amount of money that needs to be mobilized for Ministry of Health. Money is needed for the following purposes:

- Underfinancing
- Recurrent costs of projects underway
- Additional costs of fee collection and private services

Although underfinancing is obvious to Ministry of Health personnel, it has also been acknowledged by neutral government agencies: "[T]he health sector is still under-financed...." (Jamaica Institute of Planning, Statistical Yearbook of Jamaica 1991, p105). Underfinancing takes the form of:

1. Insufficient numbers of personnel and inadequate maintenance
2. Shortages of pharmaceutical (approximately half of requirements)
3. High attrition of personnel

Table I provides approximate calculations of the amount of money needed by the Ministry of Health of Jamaica (MOH) to correct underfinancing activities. As this estimate was not specifically requested in the terms of reference, it was not possible to perform a detailed assessment within the limited time for this assignment. For the present task, exact estimates are not important, because the process of implementing user fees will allow time for adjustment as more precise economic data are obtained.

Table I. Estimated increase in MOH funds needed to correct underfinancing (1992 Jamaican dollars)

1. Additional personnel and maintenance:	J\$ 92 million
2. Greater supply of pharmaceutical: (100% increase)	J\$ 80 million
3. Raise salaries of existing registered nurses (increase salaries by 50%, i.e. $973 \times \$55000 \times 50\%$):	J\$ 27 million
4. Raise salaries of existing pharmacists (increase salaries by 50%, i.e. $64 \times \$80000 \times 50\%$):	J\$ 3 million
5. Additional personnel and maintenance in primary care (estimate):	J\$ 20 million
SUBTOTAL	<u>J\$222 million</u>

The estimate required for personnel and maintenance was based on Kutzin's finding that "...an additional \$18-\$20 million [1989 Jamaican dollars] would be the financial requirement for filling currently vacant staff posts and meeting maintenance needs" (J Kutzin, Jamaica Hospital Restoration Project, Project Hope, 1989, p. xix). The midpoint of this range (J\$19 million) was extrapolated to the 1992 estimate in Table I of J\$92 million based on the devaluation of the Jamaican dollar compared to the U.S. dollar since 1989.

Although this assignment did not allow time for an independent assessment, Kutzin's (1989) analysis of the health sector was thorough and appears reasonable. The study has, in effect been ratified by both the Interamerican Development Bank and the Government of Jamaica, in that both used as the basis of a \$100 million loan to Jamaica for the Jamaica Hospital Restoration Project.

The proposed increase in nurses' and pharmacists' salaries is this consultant's subjective estimate. In the discussion of these preliminary results at the final briefing, the Ministry of Finance budget officer responsible for health and other officials emphasized that these findings could be refined with more time. Some items here may be underestimated, while other items may be overestimated. For example, nursing personnel were recently granted a pay increase that may obviate part of the need for the proposed 50% increase in their salary. On the other hand, the calculation included only registered nurses, and excluded other types of nurses (e.g. public health nurses) who may also require raises. Also, the analysis is based on expenditures and excludes costs which are not captured in the government budget. For example, some hospitals have been assisted by donations of services and supplies, which may need to be purchased in the future.

Table II. Required increases for projects underway (inflated to 1992 prices)

1.Hospital Restoration Project (in 1995, from Kutzin, 1989):	J\$ 75 million
2.Other projects (estimate):	J\$ 25 million
SUBTOTAL	<u>J\$100 million</u>
Additional costs of fee collection and private services	
1.Fee collection clerks after hours, 100 clerks x \$30,000	J\$ 3 million
2.Added costs of private beds (nursing, catering, cleaning, decorating), 700 beds x \$150/day x 365 days	J\$ 38 million
SUBTOTAL	<u>J\$ 41 million</u>
GRAND TOTAL	<u>J\$363 million</u>

Table II shows the increases required for projects underway, quality improvements, and administrative costs of fee recovery. Overall, an increase of 37% in recurrent costs (J\$ 363 million) over the MOH approved 92-93 budget (J\$ 976 million) would be needed to make existing and proposed activities of the Ministry of Health function properly. This increase would be in addition to the current support from the Ministry of Finance. It would be required by 1996, the estimated completion of the major Hospital Restoration Project of the Interamerican Development Bank. An intermediate goal for 1994 is 20% cost recovery (i.e., user fees cover 20% of recurrent costs of the MOH). These calculations assume that the Ministry of Finance continues to fund 1992-93 MOH net total budget (J\$ 880 million) with increases for inflation.

Kutzin's estimates of revenue needed to correct for personnel shortages appear to count only the increases in numbers of personnel (with existing salaries). To refine this work, his analysis would need to be reviewed more carefully to assure that it does not overlap with the separate estimate of the funds needed to raise salaries for nurses and pharmacists.

In setting the level of fees, an important constraint must be respected. The proposed fees must be affordable to the population to be served by the system. Data from the Survey of Living Conditions conducted by the Jamaica Institute of Planning (1992) can help illuminate this.

The following facts relate to the poorest consumption quintile (i.e., the poorest fifth of the Jamaican population) in 1990, adjusted to 1992 prices. Among persons in this consumption quintile seeking medical care, the proportion treated in private sector was 48.9%. Thus, existing private fees (which are much higher than those proposed for public patients) are affordable even to many in the poorest segment of Jamaican society. The mean total cost per person incurred in the last 4 weeks for private care, among those seeking such care, excluding drugs and insurance reimbursement (based on 1990 data, J\$ 50 x 3 [for inflation]) was J\$ 150. The mean costs for drugs per person seeking care in the private sector in the last four weeks was (J\$ 38 x 3) was J\$ 114. Thus, the total (for persons seeking both medical services and drugs) was J\$ 264. Although hospital admissions are relatively rare (required by only one person in 20), this amount would cover the cost of an average hospital admission in the public sector, and is much more than the proposed fee for an ambulatory visit.

Finally, the fees should be structured insofar as possible to promote rational use of health system. That is, the fees should encourage people to obtain services in ways that minimize the cost to the health care system of providing them. To do this, we will structure services to make use of public facilities in afternoons and evenings, when facilities tend to be underutilized, by establishing evening private clinics.

To encourage patients to use health centers and lower level hospitals when adequate, we recommend that the MOH:

- Maintain free care in health centers
- Graduate charges by level of hospital

Part II: STRUCTURE OF PROPOSED FEE SCHEDULE

The structure of the proposed fee schedule is based on the following principles:

- 1 For primary care: maintain free care initially, but allocate more money from budget
- 2 For secondary and tertiary care, charge for services in 3 economic levels:
 - Indigent (defined operationally as patients with food stamp aid, plus additional indigents who receive exemptions on a case-by-case basis from an assessment officer in the health facility in which they receive care)
 - Public (most of the population)
 - Private (eventually, about a quarter of inpatient care)
- 3 Graduate fees by type of hospital, so that patients pay more in more sophisticated hospitals.
- 4 Charge separately for the following types of services (based on acceptability and feasibility):
 - Inpatient (includes operating theater, physiotherapy, and laboratory)
 - Ambulatory (includes laboratory)
 - Pharmaceutical
 - X-rays

The following cost information (based largely on the work of George Cumper) is critical in setting fees. Concerning inpatient costs (expenditures), adjusted to 1992 prices, Prof. Cumper found:

- Average cost per day about J\$ 450
- Average length of stay: 6 days
- Average cost per hospitalization (6 x J\$ 450): J\$ 2700

Concerning ambulatory (casualty and outpatient) costs, also adjusted to 1992 prices, using the studies of Prof. Cumper we estimate that:

- An average casualty or outpatient visit cost J\$ 82. While Prof. Cumper did not distinguish the costs of casualty and outpatient visits, their average costs are probably similar. Only a minority of "casualty" visits are true medical emergencies. The rest are simply problems that required ambulatory care needed in the evening, weekend, or were not previously scheduled in a specialty clinic.
- Tests and procedures which would not be charged separately have additional costs, here assumed to be J\$ 18 per visit
- This consultant's estimate of total cost per visit is J\$ 100.

A proposed fee schedule for inpatient care is given in Table III. The following goals underlie this proposed schedule. First, the proposed fee schedule is based on types of admissions, which would be determined on (or shortly after) admission. This type of fee schedule provides incentives for efficient care, and promotes flexibility in treatment. The hospital gains financially by promptly scheduling and conducting any needed tests, discharging the patient quickly, and if necessary, performing aftercare at home or on an ambulatory basis after discharge. These steps also foster efficient use of heavily demanded hospital beds. This payment system also

avoids the tendency that hospitals might otherwise experience to prolong lengths of hospital stay to be able to get more revenue from insurance companies. Second, the proposed fee schedule

Table III. Proposed inpatient fee schedule: Graduated flat fees

1. SURGERY, (excluding drugs)

Level	Est. Days	Public Fee	Private Fee
A	12	\$ 540	\$ 5000
B	9	\$ 360	\$ 4000
C	6	\$ 270	\$ 3000
D	3	\$ 180	\$ 2200
Minor	1	\$ 120	\$ 1500

2. MEDICINE (excluding drugs, including rehabilitation, pediatrics, and use of intensive care)

Level	Est. Days	Public Fee	Private Fee
B	12	\$ 360	\$ 4000
C	9	\$ 270	\$ 3000
D	6	\$ 180	\$ 2200
E	3	\$ 120	\$ 1500

3. OBSTETRICS (includes both complicated and routine deliveries):

Est. Days	Public Fee	Private Fee
3	\$ 400	\$ 1600

seeks to be economically reasonable by maintaining free care for indigent patients, not charging public patients more than it appears that they could pay, and by encouraging use by private patients through substantially lower fees than in private hospitals, plus access to some of the equipment in Jamaica. Third, the system attempts to cross subsidize generally longer hospitalizations with generally shorter ones. That is, fees for less complicated admissions cover a greater share of costs than for more complicated admissions. This policy helps assure financial access, as it reduces the chance that a patient would receive a large bill that would exceed his resources or the limits of his insurance. This policy is evidenced by raising the proposed fee by less than proportional to the hypothesized length of stay for longer admissions.

For surgical admissions, the proposed fees are linked to the present four categories of surgical admissions. The present fees cover only the operation itself (surgeon, anesthesiologist, and use of the operating theater). The proposed system would expand the fee to be all inclusive, so that pre-operative, post-operative and nursing care are all included along with room and board. For

medical admissions, rules for assigning diagnoses and levels of severity to admission categories need to be developed (see below).

Table IV shows the proposed schedule for ambulatory and ancillary services. The schedule reinforces the policy previously announced by the Minister of Health that patients should pay

Table IV. Proposed Ambulatory and Ancillary Fees

A	Ambulatory Visit (includes lab tests):		
		Pub.	Priv.
		Fee	Fee
	Morning	\$ 30	Not avail.
	Afternoon/even.	\$ 50	\$ 150
B	Pharmacy		
	All drugs, same for public and private:		
	Actual cost of purchase and distribution, rounded, and including some cross-subsidies.		
C	X-rays		
		Public	Private
		Fee	Fee
	Single film	\$ 30	\$ 400
	Multiple films	\$ 60	\$ 800

for the cost of medications. It increases the hours of clinic operation by offering the convenience of afternoon and evening clinics, for an appropriate fee. The proposed private fee is comparable to the charge in private offices, for which a proposed increase is still under discussion.

Table V shows the proposed system of graduating fees according to the type of hospital. At the final debriefing, one ministry official expressed his concern with these graduated fees. He argued that types A and B hospitals, in addition to being referral hospitals from smaller hospitals, are also the local secondary hospitals for their immediate catchment area. Thus, a higher fee would penalize their immediate catchment population. While this fact is true, it is counteracted by the advantage of having more sophisticated, heavily subsidized, services close by. Furthermore, this pricing schedule is needed to discourage people from outside the primary catchment area of a specialized hospital from bypassing their local hospital. Jamaican officials will need to decide between two conflicting goals. Uniform charges at all types of hospitals will likely perpetuate the current imbalance of crowded referral hospitals and under-occupied C-level hospitals. Charges graduated by type of hospital, of the type shown in Table V, would balance two conflicting pressures. While people living near level A hospitals and B hospitals would face

higher charges, they would also enjoy more sophisticated facilities. If they wished to avoid the higher charges, they could travel to the nearest lower level hospital.

Table V. Charges by type of hospital

Hospital	Fee	Example (Delivery)
Type A	Full charge	\$ 400
Type B	15% discount	\$ 340
Type C	30% discount	\$ 280

To illustrate how this charge schedule might operate for an average (6 day) medical admission (Level D in Table III), Figure 1 examines the degree of cost recovery from the existing charge schedule (in place since 1984) of J\$ 30 per admission with the various components of the proposed new scale. Overall, the proposed schedule would recover

32% of the existing cost (in 1992 prices) of an average inpatient admission. Figures 2 and 3 contrast the share of patients and share of costs for this level of admission. The results show that while private patients are a minority (25%) of patients, they represent a majority of revenues. Thus, creating a quality of service that will attract paying private patients is critical to the success of cost recovery. These results approximate how the proposed fee schedule might recover costs for all inpatient care. For more sophisticated levels of admission (e.g. A, B, and C), the degree of cost recovery would be less; for less sophisticated levels (e.g. E) a higher proportion of costs would be recovered. A more precise estimate would require further data and analysis, as described under Part III below.

Figures 4 through 6 analyze cost recovery for a typical ambulatory care episode. Overall, the level of cost recovery is actually somewhat higher for ambulatory care than for inpatient care. The proposed public and private fees would still be substantially less than those recommended for private practice (approximately J\$ 150 now, with an increase to J\$ 250 under discussion). Improvements in the quality of service are critical to the population accepting higher user fees, and the ability of public facilities to attract private paying clients. Some of the benefits that would be offered to private inpatients and their rationale are:

1. Prompt admission to busy hospital:
Note: McFarlane & McFarlane (1987) found "quick attention from doctor" was the most commonly noted expectation. Their study found that the speed of seeing the doctor was "less than reasonable" according to 63% of respondents (unweighted average in 3 areas).
2. Attentive service from physician (private hospital patient also private patient of physician)
3. Adequate bedding available (was "less than reasonable" also to 63% of respondents, McFarlane & McFarlane, 1987)
4. Comfortable surroundings (furniture, TV or VCR, lounge, clean, less crowded, possibly private room)
5. Better food

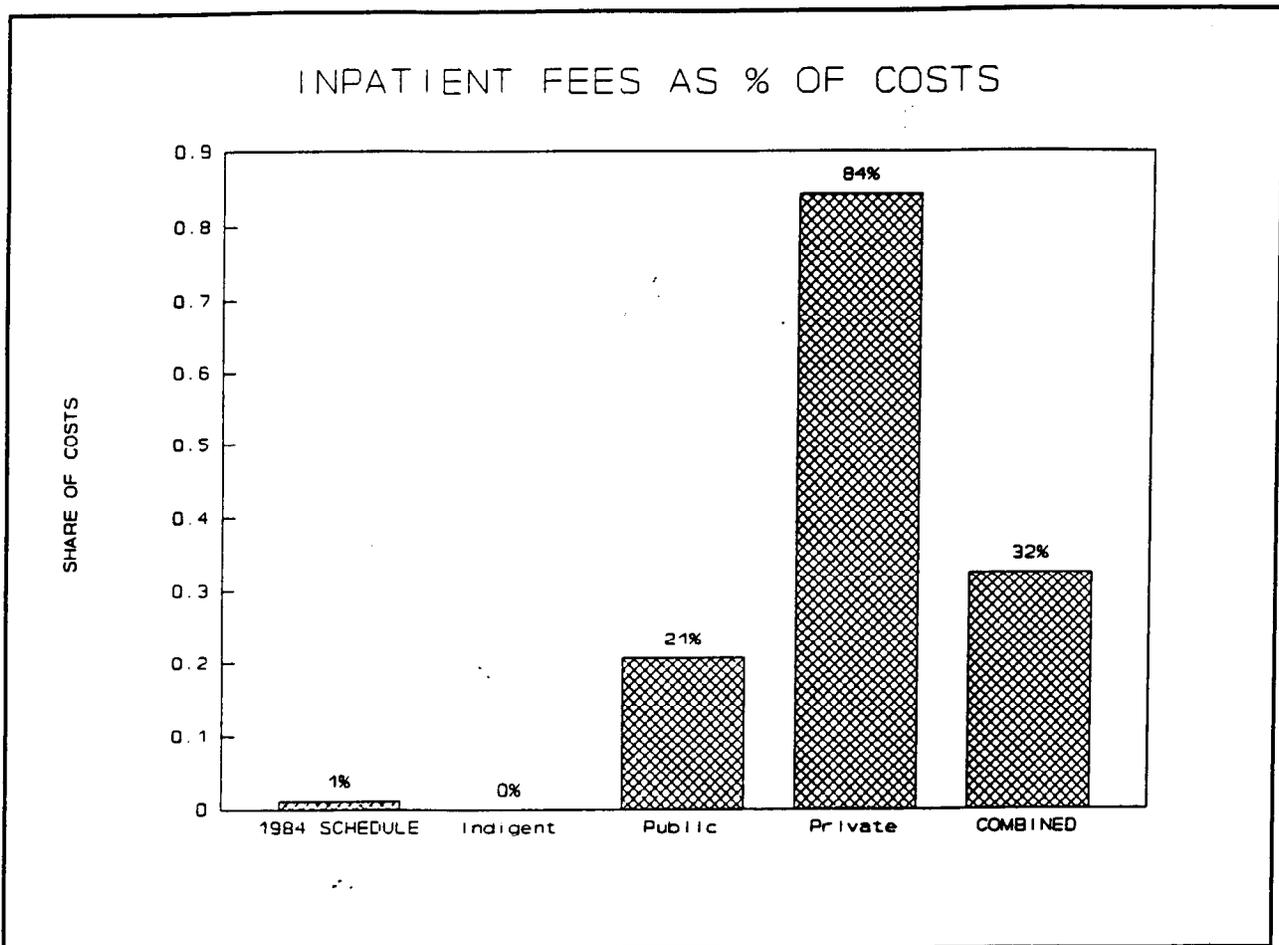


Figure 1. Inpatient Fees as % of Costs

6. Only way to be a private patient of a physician in a public hospital
7. More nurses per patient on duty
8. Less expensive than in private hospital

The proposed benefits of private ambulatory care in outpatient clinics public hospitals are:

1. Scheduled appointments (through creating an evening private clinic)
2. Uncrowded walk-ins (also in late afternoon or evening)
3. More nursing personnel on duty, achieved through a system of cross subsidies described below.
4. Convenient hours for working patients

Part III: CONCURRENT STEPS TO IMPROVE QUALITY AND ORGANIZATION OF SERVICES

All outpatient services and private inpatient services require substantial improvement to meet competition from private providers. As mentioned above, among consumers in the poorest quintile of consumption, half of those ill sought treatment from private providers. In the most affluent quintile, the share was three fourths. Although private hospitals account for only 7% of hospital beds, they probably represent more beds than the private beds in public hospitals. In short, the competition for paying patients will be keen. Only substantial efforts to improve and maintain the quality of care in public institutions will attract these patients, and assure major cost recovery.

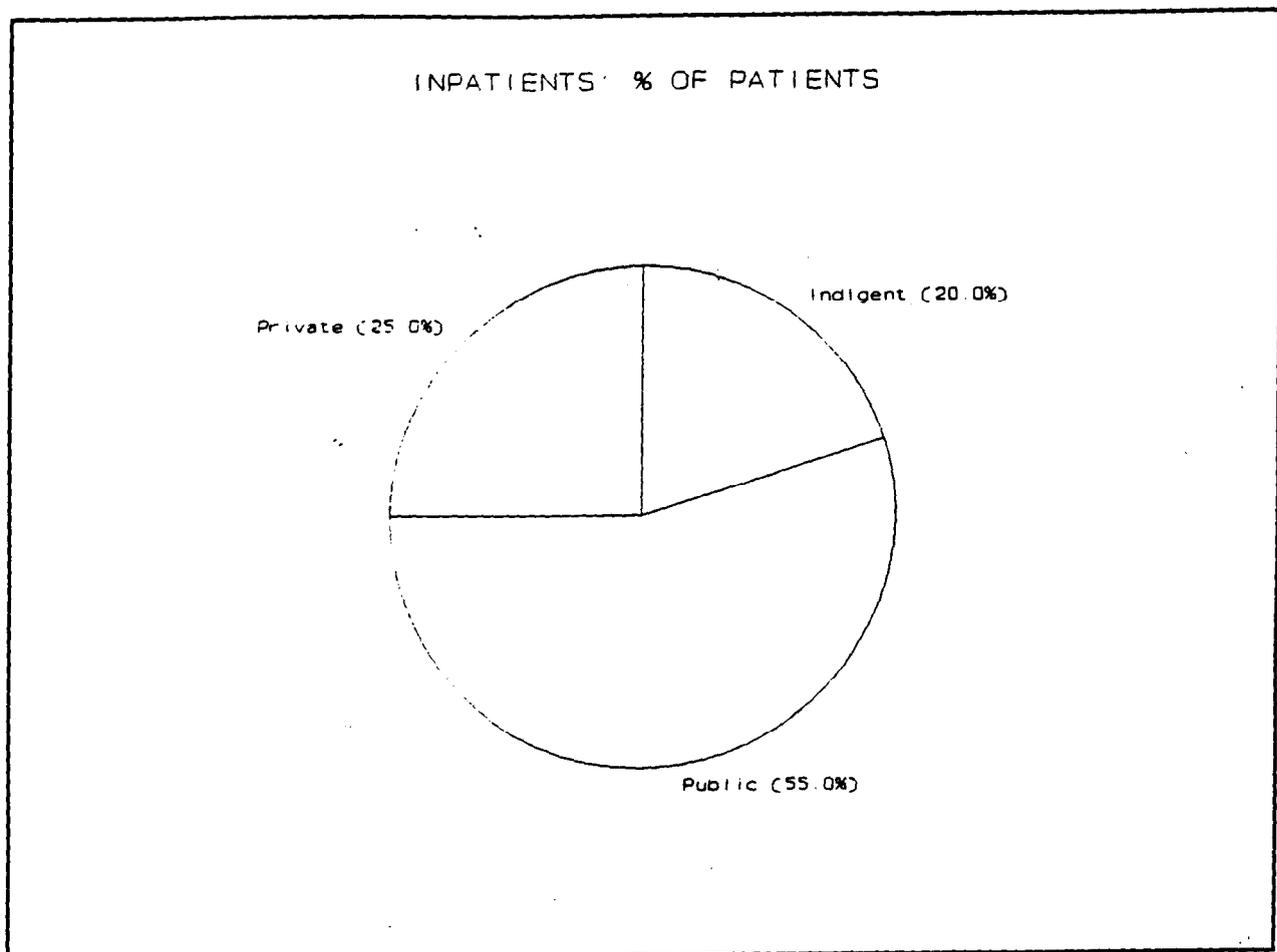


Figure 2. Inpatients: % of Patients

The suggested improvements in quality and organization to assure that patients are willing to pay fees are listed below. Fortunately, two major projects now underway can provide donor assistance in implementing these reforms. Indeed, many measures, the need for which was previously identified, are already being implemented.

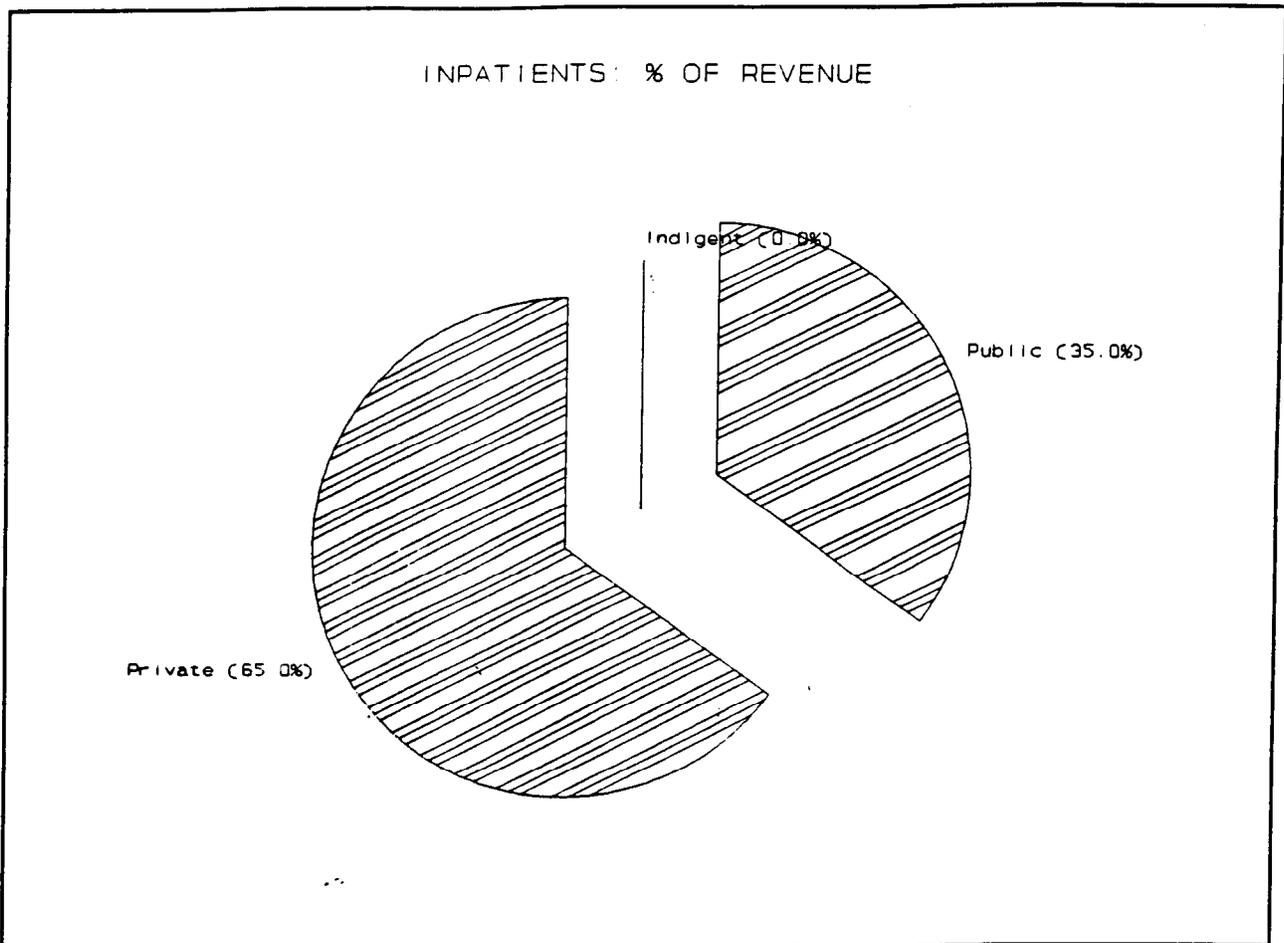


Figure 3. Inpatients: % of Revenue

- A. Improve and delineate private care**
1. Convert separate wards or rooms to private
 2. Implement training and authority of admissions officer
 3. Assure that private physicians can accelerate admission only of private patients
 4. Arrange with insurance companies: private payment to physician authorized only if hospital received private payment
- B. Improve collections of fees**
1. Require payment of a deposit from both public and private patients when admission scheduled
 2. Require patients to pay the balance of their charge prior to discharge

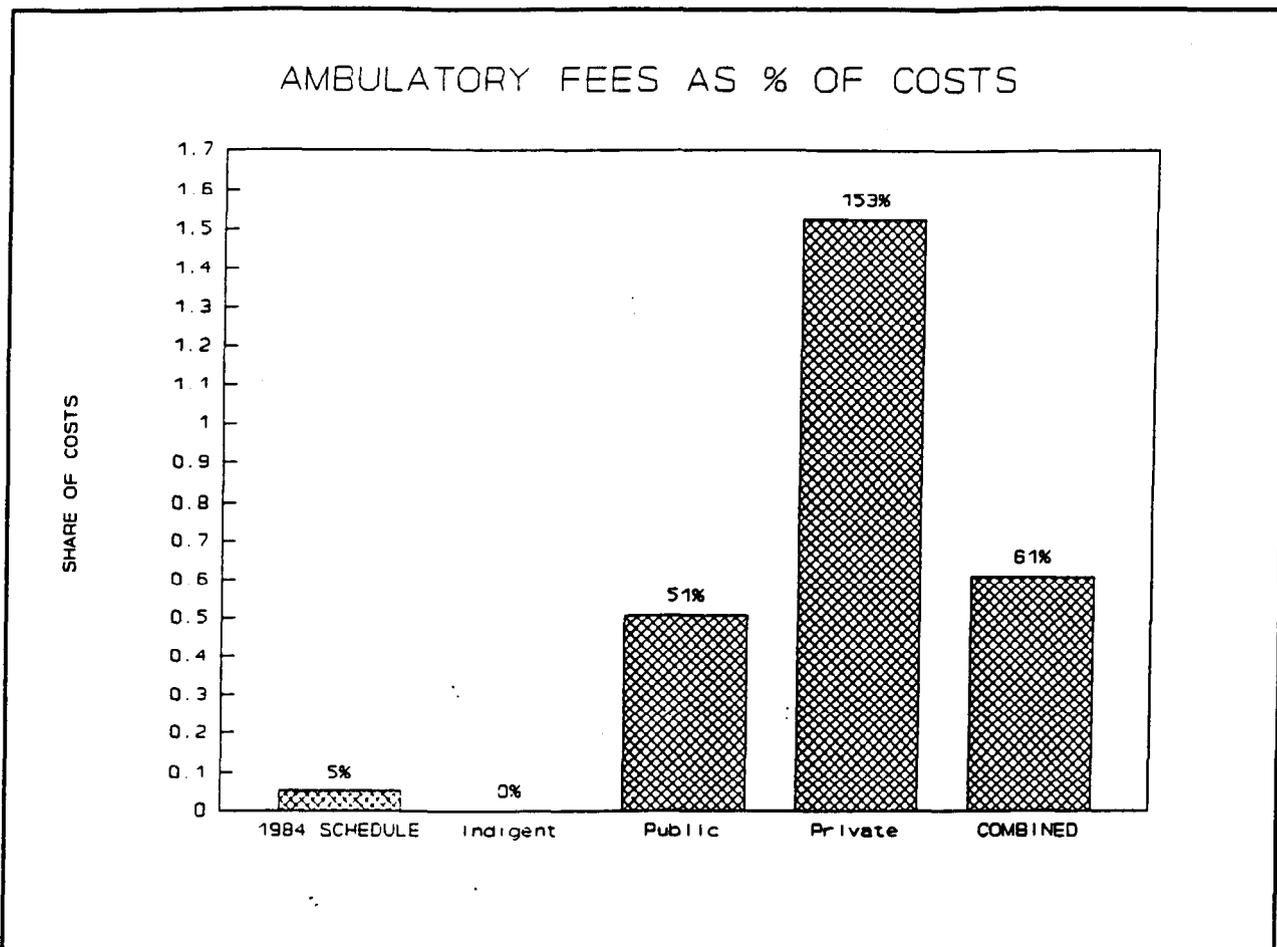


Figure 4. Ambulatory Fees as % of Costs

C. Create a staff improvement fund

1. Designate a fixed amount (e.g. J\$50) of each inpatient admission and a smaller amount (e.g. J\$10) of each ambulatory visit as a registration fee paid to a staff improvement fund.
2. Each quarter year, hospital trustees distribute the available fund balance to benefit staff, e.g. pay for amenities (e.g. hot plate, refrigerator, or medical journals) or non-taxable cash allowances (e.g. transportation allowance distributed to all staff).

D. Improve compensation of nurses to benefit public and private wards

1. Establish attractive compensation (3 times pro-rata daily salary) for shifts on private ward
2. Administer nursing roster on which a nurse can work as lucrative private shift only after a specified number of public shifts

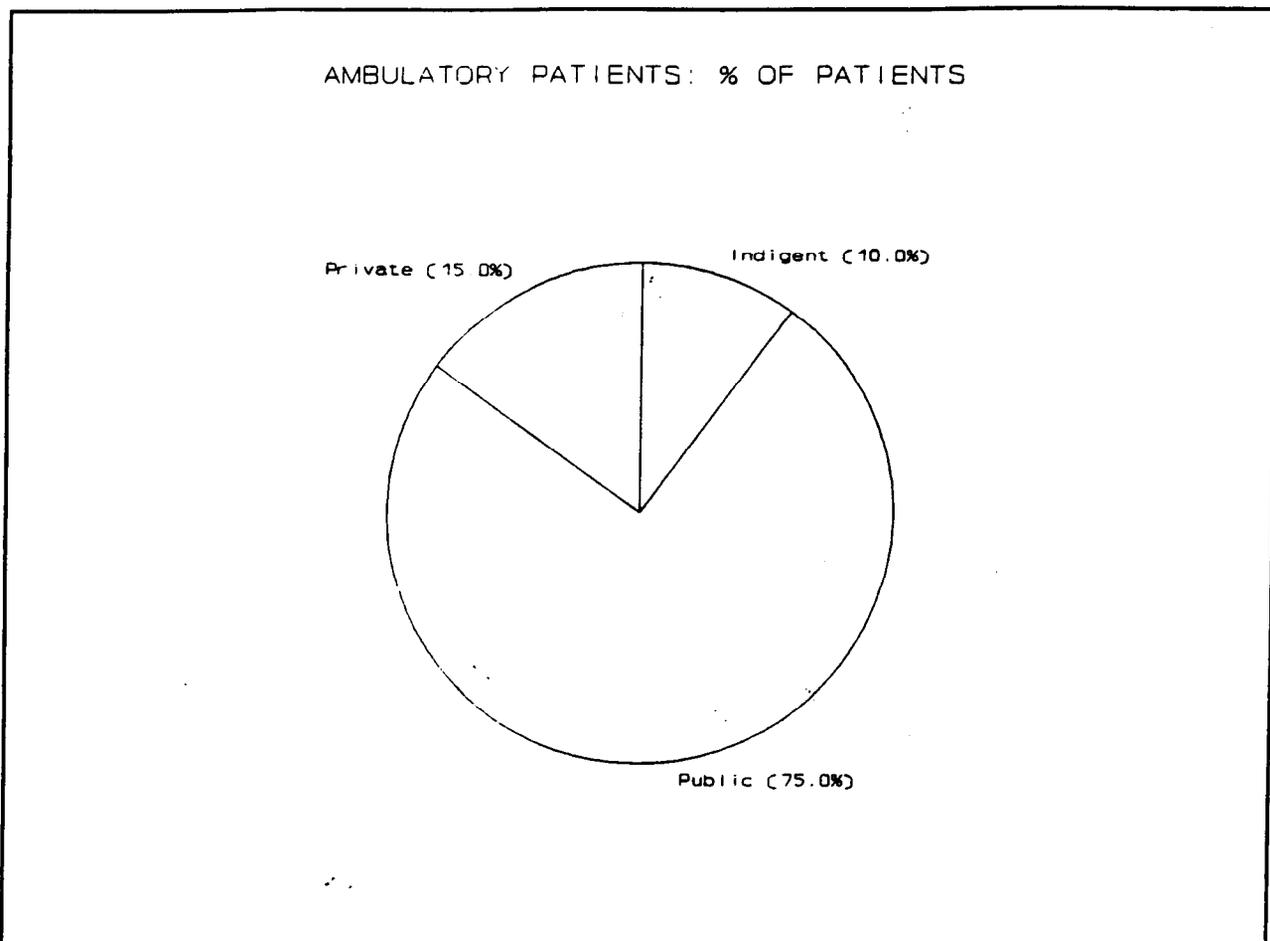


Figure 5. Ambulatory Patients: % of Patients

E. Evaluate and update the system

1. Raise fees quarterly according to an inflation index.
2. Conduct before-and-after surveys in households and at facilities to assess impact on access and satisfaction
3. Plan or implement baseline surveys to determine how the revision of fees affects patient satisfaction, delay from onset of illness to initiating care, and use of medical services. The questionnaire being developed for the social marketing study can probably be used for this purpose. If cost recovery is implemented nationally, then the survey can be repeated nationally after about 6 months to indicate how the policy is working. If the policy is being phased in, then local surveys should be done before and after in the areas selected for the first phase.

Part IV: RECOMMENDED IMPLEMENTATION PLAN

The Minister of Health is anxious that cost recovery can be implemented as rapidly as possible. To meet this goal, the Director of the HSIP would like to help the Ministry prepare a cabinet submission to be presented in early 1993, if possible. The first step chronologically is thus the preparation of a sound cabinet submission for a 1993 fee schedule. The second step is the smooth implementation of the 1992 fee schedule. The third step is the implementation of the quality and monitoring steps, described above. The steps towards this are listed below:

- A. Continue with implementation of 1992 fee revisions
 - 1. In general, continue with the implementation of the proposed 1992 fee schedule (presented to cabinet in January, 1992, and about to be gazetted). This is important to maintain the political momentum behind reforming user fees. It is based on the adage that the "perfect" should not stand in the way of the "good."

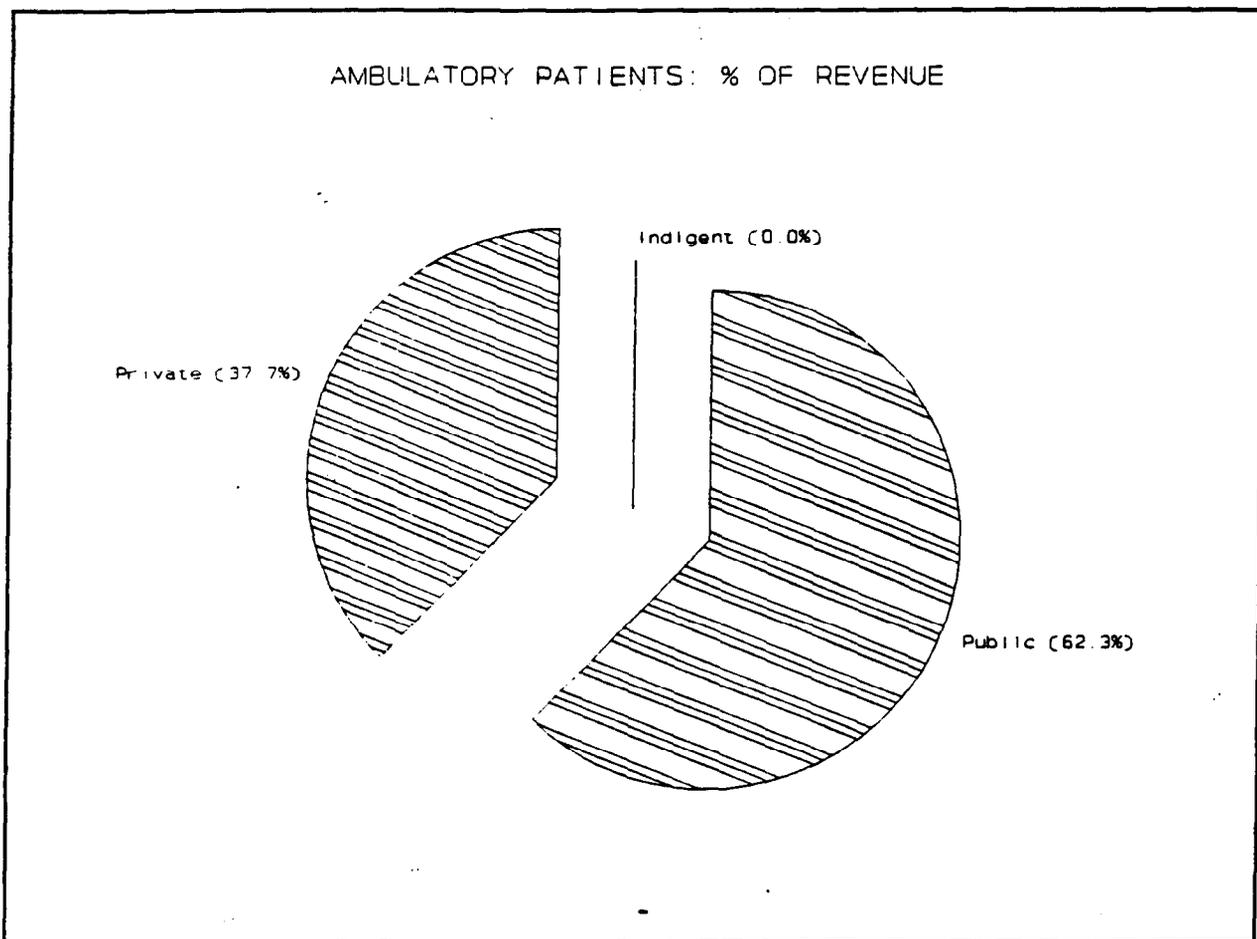


Figure 6. Ambulatory Patients: % of Revenue

2. Consider delaying implementation of one aspect of the 1992 fee schedule whose enforcement might prove difficult. That is the provision to distinguish charges by the patient's insurance status, rather than his level of service. Patients in public facilities are reluctant to disclose their insurance status if they receive no benefits in return.
3. Develop publicity about the proposed 1992 fee schedule -- posters, printed flyers, press releases, media interviews with key health officials, training of assessment officers in hospitals, etc. The publicity should indicate the new levels of fees, reasons for the increases, how the funds will be used, quality improvements being implemented, the procedure for requesting an exemption, and indicate that other changes in fees are being studied.

B. Develop a 1993 cabinet submission

1. An interim plan could be developed based on the sum of: an admission charge, a per diem charge, a surgery or delivery charge, and charges for drugs. There would be separate charges for public and private patients. Based on the graduated fees in Table III, the illustrative interim fee schedule would be as shown in Table VI. For example, the public fee for a level B, 9-day surgical admission would be: registration (J\$ 60), operating theater (J\$ 60), per diem (9 days at J\$ 30, or J\$ 270), or J\$ 390. This is close to the flat fee that was proposed for this type of hospitalization (J\$ 360).

Table VI. Proposed interim fee schedule (in J\$)

Item	Public Fee	Private Fee
Registration (for each inpatient hospital admission)	60	600
Operating theater charge (based on complexity of operation)		
A	90	900
B	60	600
C	45	450
D	30	300
Delivery charge (includes both complicated and routine deliveries)	60	600
Daily hospitalization charge (excluding drugs)	30	300

These itemized charges do not have the simplicity, incentives for efficiency, or ability to cross subsidize contained in the proposed flat fees. On the other hand, they do not require the additional analyses (described below) to categorize types of hospitalizations. Thus, they could be implemented quickly. In addition, except for the registration fee, they are similar to the current system in structure. Thus, they are likely to be readily understood by both providers and patients.

2. To move towards a system of flat fees in the future, we suggest that the Ministry give the HSIP project responsibility for this data gathering step, with the following resources. Technical assistance (approximately 4 person weeks in country, divided between two visits and/or two consultants) should be requested for economic and financial analysis; information should be requested from the health information system; research assistance should be requested at selected hospitals to abstract information on length of stay by diagnosis and problem from medical records which is not currently part of the information system.
3. Develop information on the average length of hospital stay for various types of surgical operations and medical admissions. This information will allow providers and hospital registrars to classify admissions as A, B, C, D, or minor so both staff and patients will know the charges. This classification should be based on information from the health information system (if it contains lengths of stay by diagnosis or procedure), or information abstracted from a sample of medical records at selected hospitals. The United States Medicare reimbursement system, with hundreds of Diagnostic Related Groups, and dozens of Major Diagnostic Categories, can provide a foundation this classification. Foreign technical assistance can be useful in organizing and interpreting these data.
4. Review and revise proposed fee schedule which was presented to the Ministry on October 9, and is contained in this report.
5. Develop detailed justification for proposed schedule of fees.
6. Decide on phased versus national implementation based on the considerations below. A policy of phased implementation would implement cost recovery in 2 to 5 more hospitals every 4 months. The order of phasing should be based on readiness and balance, until all included. Table VII lists a possible schedule. The advantages of phased implementation are that it:
 - Allows training, administrative procedures, and redecorating to precede the attempt to collect higher fees.
 - Increases the likelihood that quality improves before or concurrent with greater cost recovery.

On the other hand, the potential advantages of national implementation:

- Maintains the policy initiative towards cost recovery.
- Avoids inter-regional jealousies from different fee levels.
- Allows social marketing with electronic media.
- May allow more rapid increase in revenue if implementation is satisfactory.
- Allows all training of administrative personnel to proceed simultaneously.

Table VII. Proposed schedule for phased implementation of user fees

The following calendar is recommended for 1993 under a two year schedule:

- 2 Type B hospitals (Savannah La Mar and Spanish Town)
- 2 Type A or specialty hospitals (Cornwall Regional) and Bustamante
- Half of type C hospitals (specific hospitals to be determined)

The following calendar is recommended for 1994 as the second year under a two year schedule:

- Remaining Type B hospitals
 - Remaining Type A and specialty hospitals
 - Remaining Type C hospitals
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Table VIII lists a schedule for national implementation. Although this analyst favors the phased implementation, it is recognized that the implementation schedule is a political, rather than a scientific, question. Still another option would be to phase in implementation by type of hospital.

Table VIII. Proposed steps for national implementation of higher fees

- 1 Develop cabinet submission to be presented in early 1993.
 - 2 Plan implementation to begin six months after cabinet approval.
 - 3 Discuss changes with physician community, other health professionals, and hospital boards.
 - 4 Initiate quality improvements and monitoring efforts.
 - 5 Publicize fee changes and quality improvements.
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In March, 1993, after considering an earlier draft of this report, the Ministry of Health decided that it wished to consider user fees for primary care services along with those for hospital services. This consultant has been invited to outline the steps required to assist Government of Jamaica in creating a specific proposal, and looks forward to the opportunity to contribute to this process.