

Evaluation of Health Sector Initiatives Program

Prepared for USAID, Kingston, Jamaica

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September 21, 1998

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ACKNOWLEDGMENTS

The authors of this evaluation are indebted to the many officials of USAID/Kingston and of the Ministry of Health for their insights, openness, and flexibility in providing us with support and information over the course of this evaluation. The full list of persons interviewed is given in Appendix A. The authors want to convey special thanks to the four Regional Directors (Paola Arscott, Owen Belvett, Fay Petgrave, and Sheila Campbell-Forrester), the Chief Executive Officers of the hospitals visited, Miss Hyacinth Allen, Dr. Peter Figueroa, Dr. Marjorie Holding-Cobham, and Mr. Stanley Lalta of the Ministry of Health, and Mr. Daniel Gordon, Ms. Grace Ann Grey, and Ms. Bridget Fong Yee of USAID/Kingston. Responsibility for the contents of this report rests, however, solely with the authors.

1. EXECUTIVE SUMMARY AND LESSONS LEARNED

1.1 Objectives

The purpose of the evaluation is to: (1) assess the extent to which health reform activities under the Health Sector Initiatives Project (HSIP) have achieved their objectives, (2) provide recommendations regarding what is needed to promote the sustainability of these activities, once USAID assistance ends, and (3) provide accomplishments and lessons learned in the areas of cost recovery, decentralization and divestment to the Mission, AID/W, MOH and others regarding health policy reform.

1.2 Approach

The statement of work prepared by USAID is shown in Appendix D, and the evaluation team's workplan is in Appendix C. The evaluation team met and compiled most of the data for this report in Jamaica from August 9 through 20, 1998 through site visits to nine hospitals (2 for cost recovery only, 2 for divestment only, and 5 for both), interviews with all four Regional Directors, and discussions with staff of the Ministry of Health, the HSIP, and USAID. Previous reports and budgets were reviewed, statistical data on user fees from the HSIP were analyzed, and services data from the Health Information Unit of the Ministry of Health were obtained. In addition, two types of original data were compiled: interviews with an average of one hospitalized patient per hospital to gain impressions about divestment and cost recovery, and a systematic sample of inpatient bills and payments in 6 study hospitals. Unless indicated otherwise, all amounts in this report are in Jamaican dollars (J\$). In 1998, J\$36 equals US \$1. Preliminary results were presented on August 18, 1998 at USAID and on August 19, 1998 at the Ministry of Health. On Sept. 17, 1998, the authors received written comments from the Ministry on the draft report. The principal findings and lessons learned were as follows:

1.3 Divestment.

With some exceptions, divestment has succeeded in raising quality – providing a better service. It has worked primarily in the areas of cleaning/portering, dietary, and security. Data for cost comparisons have been hard to obtain. They suggest there have been savings in dietary, due to less food loss and less provision of unauthorized meals. In cleaning and portering, there has not

been much cost change, with the results depending on whether the calculations are done before or after a major government salary adjustment. In security, costs have generally increased due to more staff and a more professional service. Impacts on employment appear to have been minimal. For cleaning and portering, the contracts generally specified the staffing required. If those standards were observed (as they were in most cases), little reduction would result. In security, the contracts often required more staffing than existed previously. Overall, there appears to have been little change in staffing.

Based on this evaluation, the team recommends:

- Continuing with the divesting program since public sector salaries have moved so significantly in comparison to the tender requests,
- Amending the catering contracts to stipulate a minimum of four hours on site by the contractor's dietitian. The time must include the preparation period of at least two meals.
- Reviewing the amount of security coverage purchased to avoid excessive expenditures. Except at KPH, security coverage needs should be reviewed as has been shown in Mandeville.
- Extending the divestment program to other areas as suggested in the original policy document (diagnostic services including pharmacy), as well as such additional areas as accounting, warehousing (Stores), transportation and communications.

One main lesson learned is the need for more incentives related to quality. While hospitals have set up procedures for monitoring quality through surveys of patients and responsible hospital officials, contractors receive almost no reward for exceeding the minimal contract standards, and only weak and delayed sanctions when they fail to perform. For example, the one instance in which the hospital was so dissatisfied with quality that it was seeking premature termination for non-performance (Bustamante Hospital contract with DIMACS for cleaning and portering services) seemed to have little adverse impact on the contractor. The concerns had not been communicated to the administrator of another hospital, who chose the same contractor. The sanction for understaffing, withholding payment for the direct cost of contract services not provided, provided little penalty.

1.4 Cost recovery

The HSIP program has made good progress in cost recovery. The most important accomplishment is establishing an expectation that patients pay a share of the cost. Current procedures attain high compliance (about 80%) for ambulatory care, and partial compliance (about 50%) for inpatient care. Current revenues from cost recovery are about 9% of the annual expenditures. The team recommended increasing cost recovery, both to raise additional revenues, and to move towards a system of public financing towards the planned National Health Insurance. This can be achieved through increases in the fee schedule, and steps to improve compliance among inpatients (asking for deposits on admission or slightly thereafter, generating frequent interim bills, and requesting as much of possible of the outstanding balance upon discharge). For ambulatory services, hospitals already exempt those unable to pay and enforce collection for those not exempted. Similar policies should be implemented for inpatient services.

As the MOH moves towards its consideration of National Health Insurance, cost recovery for inpatient services can, and should, be pursued vigorously. The current level of fees for inpatient services, even if optimally applied (about 80% of inpatients), would generate only 17% of hospital expenditures. Currently, with only nominal fees and sporadic enforcement, patients would have little interest in paying premiums for health insurance.

Hospitals should be encouraged to set their own fees, and to explain their policies to patients. Some government officials feel that Jamaica's small size requires uniform fees across the island. The evaluators feel that uniform fees are neither politically nor economically sensible, as costs and quality of services, as well as ability to pay, vary among institutions. Similarly, the abilities vary among hospitals to explain the importance of fee collection, to implement a policy of exemptions, to update fees with inflation, and to accept the political criticisms accompanying user fees. A national policy seems to force all hospitals to the lowest common denominator of the poorest, least informed, and most politically volatile patients.

1.5 Decentralization.

While substantial progress had been made in recent months, the four regional directors have been asked to perform a task with inadequate induction and support. The team recommends that the MOH facilitate the regional directors in carrying out the tasks to which the legislation charges them. Decentralization will require changes in the Ministry of Health headquarters, as it focuses on strategic management of the health system, rather than on operational management of services and institutions

1.6 Limitations of this Evaluation.

This evaluation faced major limitations of available documentation and time. Because of their limited distribution, few documents were available to the evaluation team, and none were provided before the team arrived.

The time constraints resulted both from the limited number of work days requested (36 days), and the many steps required from initiating the evaluation through the closing of the HSIP project itself. Because of these time constraints, some areas of HSIP (efforts to develop private insurance and expand the private sector) could not be considered at all, and one of the areas included (decentralization) could be allocated only five days.

2. DIVESTMENT OF SUPPORT SERVICES IN HOSPITALS

2.1 Overview

The Divestment of Services in the Ministry of Health falls within the overall policy framework of the Privatization activities of the Government of Jamaica. The assigning of the portfolio activity to the Office of the Prime Minister in December 1990 'reflected the importance ascribed to the privatization process as a fundamental strategy of the government to achieve growth and development within the context of a market economy. The National Investment Bank of Jamaica Limited (NIBJ) was also placed within the same portfolio and will continue to be the

coordinating and implementing agency for privatization activities.” (Jamaica Ministry of Health, 1991).

Privatization has attracted much attention in Jamaica. The objectives of the policy as part of a general strategy was to liberalize the economy by

- removing excessive bureaucratic intervention by government in the market-place, without sacrificing its essential role as regulator
- securing greater efficiency in the operations of enterprises,
- optimizing the use of government’s fiscal and management resources; and,
- widening the base of ownership and direct equity participation in the economy.

The Ministry of Health (MOH), in implementing government policy, used Divestment of Services as a public administration tool to

- promote greater direct participation of private groups in the provision of hospital support services - an initial step in broadening the role of private groups in the delivery of health care; and
- advance viable options for underutilized facilities.

The MOH developed its own additional policies and procedures the main one of which was to limit to four (4) the number of institutions in which a single contractor could provide service, of which not more than two could be Type “A” hospitals. Its rationale for the divestment program was to:

- improve the quality and standard of services provided by the hospital through in-house operations;
- reduce the budgetary demands of the MOH;
- improve and sustain greater cost effectiveness of hospital operations;
- promote greater operational efficiency by the use of improved management capabilities and systems of monitoring and accountability; and
- reduce pilfering, misuse and wastage of hospital resources (Prince, 1996).

All the institutions that divested Janitorial and Portering services retained and maintained direct control of the ancillary staff in the Operating Theatres. All except Kingston Public Hospital, also retained control over the Accident & Emergency Units. The contracts specified the number of employees (female and male attendants and porters) that the contractor was required to provide and maintain at each institution. These numbers more or less, approximated the cadres prior to divestment. Again, the Kingston Public Hospital was the exception, because of the significant number of temporary porters and attendants on the staff prior to divestment and which were **not** included for in the specifications.

Overall, the impact of the program on employment in the hospital system was minimal. In cleaning and portering, as mentioned, the number of contracted staff approximated the number of government staff prior to divestment at all hospitals except KPH, where not all temporary staff were replaced. On the other hand, the new security contracts generated increases in employment for that service.

Divestment of janitorial services apparently also had an indirect effect in generating employment. A number of the contracting firms “grew” in janitorial strength and garnered contracts for servicing the significant number of new office buildings which sprung up across the island’s urban centers. For instance, one company indicated that their staff had grown threefold over the past four years and it now has to maintain administrative and supervisory staff in both Kingston and Montego Bay.

All seven hospitals were visited to obtain first hand information on the operations of the divested services and the performance of the contractors. Interviews were conducted with key hospital staff, contractors’ representatives and a small sample of [in] patients. (We were fortunate to interview, without his knowing our purpose, one patient who was returning for outpatient follow up care after admission at Savanna la mar hospital, who ‘sang the praises” of the newly introduced security service.

Patient satisfaction surveys on the service before and after divestment is one of the most efficient indicators of quality. This, along with a comparative cost analysis of the services for the similar periods (both at constant dollars) would give a true indication of the effectiveness of the program(s). While this was not possible in the time allowed for the study, a significant amount of information and data from previous satisfaction surveys done by the individual hospital staff as part of their contract monitoring program were available to allow for appropriate assessment of the service.

2.2 Purpose and methodology of study

The purpose of the divestment evaluation was to review the Divestment Program introduced in seven hospitals across the island, to assess the impact of the divested service on health care delivery and to determine inter alia, the success factors, or otherwise that would facilitate continued support for the program by external funding agencies.

The divestment experiences were studied at the following institutions:

Institutions	Service	Date Divested
Savanna-la-mar Hospital	Security	Apr 1, 1998
	Dietary	May 1, 1996
Spanish Town Hospital	Janitorial & Porterage	1990/91
	Security	April, 1998 *
	Laundry	Jan 1, 1996
	Dietary	July 1, 1995
May Pen Hospital	Janitorial & Porterage	November 1997
	Security	October 1996
	Dietary	November 1997
Mandeville Hospital	Janitorial & Porterage	January 1, 1996
	Security	January 1, 1997
Kingston Public Hospital	Janitorial & Porterage	1990/91
	Security	Nov 1, 1997

	Dietary	Jan 1, 1996
Cornwall Regional Hospital	Janitorial & Portering	April 14, 1997
Bustamante Hospital	Janitorial & Portering	April 1, 1997

* The first contract was a pilot project, which started in January 1992.

It was also possible to draw on the assessment by knowledgeable hospital staff to determine the impact of the service before and after divestment. The Contract Compliance officer, Chief Executive Officer, and Director of Nursing Service/Matron, as well as the Nursing sister in major wards that interacts with the divested service were particularly revealing. Please see list of persons interviewed in Appendix A.

With respect to cost data, very few hospitals were able to provide the operational cost of services before divestment. However, the present cost of the divested service when compared with the computed relevant Personal Emoluments costs at 1997/98 salary levels, provided significant information.

2.3. *Savanna la Mar Hospital*

Located in the capital town of the parish of Westmorland, this two hundred bed Type B general hospital provides referral services in general surgery (with a two room Operating theatre suite) and medicine, pediatrics and gynecology and obstetrics, twenty four service to the community through its casualty and Accident & Emergency unit and an Out Patient service which includes a community based Psychiatry clinic service. Average Length of stay is five and one half days (5 ½), with a seventy five % average occupancy. The hospital's catchment area includes the largest sugar estate on the island and the Negril Tourist resort area.

Prior to divestment, the institution experienced high costs of maintaining food stores, large numbers of unaccounted for meals and purchasing procedures, which encouraged unnecessarily high "usage" of groceries and ground provisions. In the area of security, the hospital had a number of break-ins and robberies at the Nurses home, experienced trespassing on the compound by persons seeking to use the hospital compound as shortcut and as grazing land for their cattle and encountered the nuisance of "peeping toms" at the Nurses Home & the Labor ward.

Divestment of the dietary and security services addressed these problems. A summary of the findings at the hospital is shown in Table 2.1. All members of staff interviewed were satisfied with the improved service by the contractor. The nursing staff was particularly pleased with the cleanliness of the patient care areas and with the visible security presence on the compound.

Contracts monitoring procedures have been instituted with the Hospital Administrator \CEO monitoring the security service and the Dietitian, the dietary service. The monitoring activities included regular formal monthly meeting with contractors and periodic patient satisfaction surveys. One interesting feature at Savanna la mar was the CEO's confidence in his "walk-about-for-feedback" evaluation tool. He was sure that this assisted greatly in cultivating the contractors' willingness to correct deviations and errors.

Since divestment of the dietary service, the contractor has served 5% fewer meals, or an average monthly reduction of six hundred and ninety two (692) meals. Expenditure in 1995/96 totaled \$8.537 million - \$4.258 million for “Food and Drink plus \$4.279 million for Personal Emoluments for 29 members of staff using the 95/96 salary levels. In 1996/97 the contractor was paid \$6.284 million post divestment--a significant cost savings of just under \$3M after adjusting for the 17% inflation rate declared by STATIN for 1996/97.

TABLE 2.1. EVALUATION SUMMARY OF DIVESTMENT PROGRAMME - SAVANNA-LA-MAR HOSPITAL

Service	Service impact/cost Before Divestment	Service impact/cost after Divestment	Remarks
Security Apr 1, 1998	Break-ins /robberies at Nurses home, trespassing (human /cattle), peeping toms(N/H & Labor ward) Security provided by porters assigned as Watchmen	Strong security presence. Feeling of security particularly at night & visiting hour. Metal scan (for knives etc)of visitors at hospital entrance. Enforcement of dress code. Escort services for nurses on night duty. Nurses now satisfied with the handling of prisoners.	Divestment process followed standard procedure. Rent-a-shirt business
Costs		\$m per annum	New Service - additional expense
Dietary May, 1996	Large number of meals unaccounted for. High cost of maintaining food stores. Purchasing procedures encouraged unnecessarily high “usage” of groceries and ground provisions. Meals served per month – 12,728	Pilfering now cost to contractor. Contractor disturbed about quality of equipment – state of disrepair. Contractor paid for 12036 per month. Dietitian has more time to council In & Out-patients	Satisfaction surveys conducted. Daily contact with contractor
Costs	\$8.356 million per annum	\$6.284 million paid to contractor	Significant cost saving.

2.4. Spanish Town hospital

The Spanish Town Hospital is located in the capital town of the largest parish in the island St Catherine. It is a general Type B hospital providing referral services in general medicine, general surgery, obstetrics and gynecology, pediatrics, medicine and surgery, anaesthetic, radiology and pathology plus a 24-hour Casualty and Emergency Service daily and on weekends.

Spanish Town Hospital was identified as “a pilot institution for introducing the Contracting out of Services in order to streamline the divestment of hospital support services and to assess its feasibility as an alternative approach to public management. One hundred and thirty (130)

hospital staff were made redundant as part of the program and “the first contractor commenced operation on October 1, 1993 with a total staff complement of 122... At the end of the two year contract period in September 1995, that number increased to 147” (Prince, 1996).

All the key members of staff interviewed were firm in their view that the divestment program had resulted in improved quality and standard of and greater operational efficiency in all the support services. The use of contractors had also improved the capabilities of the management team through systems monitoring and accountability. For instance, it was pointed out that the long experience of the hospital (since 1991 when the first pilot started) allowed the Contracts Monitoring Officer to take on the additional administrative duties of managing the maintenance services.

Since divestment of the dietary service, the contractor has served 8.6% fewer meals, or an average monthly reduction of one thousand eight hundred and thirty five meals. Current expenditure is \$1.4 million per month (\$16.8 million p/a) paid to the contractor.

An evaluation of the Spanish Town experience observed that “it is expected that improvement in the quality and level of services will be accompanied by increases in operational costs and found that the contracted service costs was 21% above the cost of the in-house provided service prior to divestment”. (Prince, 1996, pp. 43).

A summary of our findings at the hospital is shown in Table 2.2.

**TABLE 2.2. EVALUATION SUMMARY OF DIVESTMENT PROGRAMME -
SPANISH TOWN HOSPITAL**

Service	Service impact/cost Before Divestment	Service impact/cost after Divestment	Remarks
Janitorial & Portering 1990/91 Includes landscaping, sanitation & pest control	High levels of indiscipline (late arrivals, absenteeism), Union activity/bureaucratic red tape made application of sanctions difficult. Little control over additional costs for overtime, vacation leave and other staff costs.	Hospital cleaner. The "hidden" personnel cost now borne by contractor.	Divestment process followed standard procedure. New post created for Contract Monitoring Officer. Monthly summary
Cost		\$16.8 million	
Laundry	Same as for Janitorial & Portering. Linen shortages, pilfering, nursing staff embarrassment	Headache relieved since Nursing staff no longer supervises linen room staff. Improved linen service.	Significant improvement in worker attitude
Cost		\$7.308 million	
Security	No control of entrance to hospital, visiting hours, feelings of insecurity by nurses at work and in nurses home.	Organized service, security presence. Good traffic control on compound.	
Cost		\$5.676 million	
Dietary	Large number of unaccounted for meals. Ave number of meals served per month 22,968	Pays only for meals delivered to patients. Contractor's dietitian major help with special diets. Meals served 21,133 per month.	Significant improvement in efficiency in HR Dept
Cost		\$16.8 million	

2.5 May Pen Hospital

The new May Pen hospital was opened in October 1997. Located in one of the fastest growing urban areas, this Type C 110 bed hospital provides basic secondary care in general surgery and medicine, pediatrics, obstetrics and gynecology. Its Casualty/Accident & Emergency unit provides 24-hour coverage including weekends and public holidays.

The opening of the new hospital has resulted in a 57% increase in the bed complement over the old hospital (110 beds now versus 70 previously). This explains the large increase in the

contract price of the services when compared with providing it in house before divestment. Dietary costs increased by 31% while Janitorial costs were 100%. However, the janitorial contract includes the floor area of the old hospital as well as the two unopened wards of the new institution. District Constables previously provided security service.

Under the contract, 20,000-sq. ft. of space in the old hospital is to be maintained at \$18.18 per sq. ft. or an expenditure of \$2.364 million per annum. This expenditure compares with \$5.983 million prior to divestment, a significant cost saving even before adjusting for inflation. Also, the new contract employed sixty-five (65) persons to maintain the new bed complement - seven more than the prorated number based on the staffing prior to divestment.

All staff and patients interviewed expressed pleasure with the new service provided by the contractors when compared to the old, although a serious reservation was expressed concerning “the allocation of very scarce resources for security services instead of for more efficacious purposes as purchasing pharmaceuticals or diagnostic equipment.”

The significantly improved facilities and accommodation of a new complex may have also contributed to the favorable evaluation. The Matron, however, pointed out that bathroom facilities in particular, can be readily assessed as clean or otherwise whether they are old or new and that the contractors’ services the maintenance of the grounds have made a considerable difference--except with respect to-- to patient care delivery.

The Commissioning Coordinator undertook contract Monitoring from the Head Office of the MOH and copies of the evaluation tools were provided for our perusal. Dietary continued to pose a problem for the contractor who is still operating out of the kitchen in the old hospital. The [regional] Dietitian has done satisfaction surveys. We were told that the main problems related to lateness and temperature of meals. Issues of quality and quantity were absent. Table 2.3 shows a summary of the findings at May Pen.

**TABLE 2.3. EVALUATION SUMMARY OF DIVESTMENT PROGRAMME -
MAY PEN HOSPITAL**

Service	Service impact/cost Before Divestment	Service impact/cost after Divestment	Remarks
Janitorial & Portering	Bureaucratic red tape made application of sanctions difficult. Little control over additional costs for overtime, vacation leave and other staff costs.	Hospital cleaner. The “hidden” personnel cost now borne by contractor.	New Contract included old hospital floor area. Increased bed complement 70 to 110
Cost	\$5.983 million	\$13.0 million	See comment above
Security	Service provided by District Constables (6)	Improved traffic and crowd control. Escort service for nurses on night duty. Secure feeling in nurses’ home. Losses of equipment refunded by Security contractor – three instances since startup.	Reservation about efficacy of expenditure.
Cost	\$0.502 million	\$7.0 million	
Dietary	Staff loyal in spite of aggressive union activity. Late meals due mainly to equipment problems.	Service improved but still affected by equipment problems. Meals late and sometimes cold.	Staff sure situation will improve immensely when kitchen in new hospital is commissioned
Cost	\$3.818 million	\$5.0 million	

2.6 Mandeville Hospital

The Mandeville Hospital is located in the center of the island high up in the hills of “bauxite country”. The 240 bed Type B hospital provides referral services in general surgery and medicine, obstetrics and gynecology, pediatrics and psychiatry to two type C hospitals at Spaldings and Black River. It also provides a 24-hour casualty and emergency service.

The institution is undergoing substantial refurbishing and expansion and this has posed difficult challenges for the security service even though the Hospital Board reduced the size of security staff after two month’s operations as a cost reduction exercise.

The Staff are enthused with the effects of the divestment program and suggests its expansion, though the Employee Share Ownership Program (ESOP) scheme, to provide Laundry, dietary and transportation services.

Table 2.4 below is a summary of the findings during our visit to Mandeville. We were advised that two satisfaction surveys done produced good results and supported the decision to divest the services. However, like at May Pen, we also had expressed a reservation about the use of scarce resources for security and the quality implications of a janitorial service which can and does suffer from high staff turnover.

**TABLE 2.4. EVALUATION SUMMARY OF DIVESTMENT PROGRAMME -
MANDEVILLE HOSPITAL**

Service	Service impact/cost Before Divestment	Service impact/cost after Divestment	Remarks
Janitorial & Portering	Bureaucratic red tape made application of sanctions difficult. Little control over additional costs for overtime, vacation leave and other staff costs.	Hospital cleaner, no smells, well kept bathrooms. Patients now coming from private care.	The “hidden” personnel cost now borne by contractor.
Cost	\$6.34 million	\$8.361 million	
Security	Service provided by District Constables. Trespassing, pilfering usually in days.	Significantly improved crowd control. No pilfering since.	Reservation about efficacy of expenditure
Cost		\$5.544 million	\$3.422 million after the cost reduction exercise

2.7 Kingston Public Hospital

The Kingston Public Hospital (KPH) along with the Victoria Jubilee Hospital (VJH) is the largest medical facility in the island. Situated in the heart of the downtown area of the city, KPH/VJH provides specialist referral services for the whole island and its 24-hour Casualty and Emergency services see over 52,200 cases annually.

Like Mandeville, KPH is undergoing substantial refurbishing and expansion to add to its usual difficult challenges for security service. When completed the bed complement will be 535.

The institution has a long experience of contract services. The Janitorial and Portering service was contracted out in 1990. The other services were added in January 1, 1996 (Dietary) and November 1, 1997 (Security). Hence all the standard monitoring procedures are in place and used to advantage. Our findings are summarized in Table 2.5.

The administration, including nursing is pleased with the concepts and objectives of divestment. The improvements in the quality of the janitorial and portering services fully justifies the policy,

particularly when compared to the period previously and the headaches which the personnel problems created. There has also been significant improvement in the security services and the confidence of the staff reflects this.

Improvement has also occurred in the efficiency of the Human Resource Development department. For instance, we were told that staff were now actually receiving approval of their leave before going off complete with pay roll advice; or, training needs now being addressed; the department can now and does provide counseling sessions for staff.

It is the Catering/Dietary contract that poses the greatest problems because of the following factors:

- the meals are prepared off site and therefore quick corrections of contractor's errors are almost impossible;
- the delivery time for meals are usually late while for supper it is usually too early and this results in a number of spoilt meals.. The contractor points to the traffic hazards at the agreed supertime. Although no charge to the hospital, it creates enormous inconveniences to replace the meal and the patient suffers;
- the plethora of documented complaints has resulted in the contractor ignoring them thereby raising the concern of a developing "monopoly attitude" as it related to the larger hospitals;
- there appears to be a high turnover of the contractor's staff and this raises concerns about the need to check for Food handlers Permits;
- the difficulty in recruiting dietetic assistants as the University of Technology no longer trains them.

The in-house services were undertaken by the following employees:

- 80 persons for dietary
- 210 male and female orderlies for cleaning and portering (mostly temporary workers). The hospital retained a some of these persons for Casualty & Emergency and the theatres. Hospital officials considered the staffing excessive, however, so the contract called for fewer workers than previously present in the department affected.

Computing the emoluments at 1997/98 salary level reveals the following:

- Dietary would have a salary bill of \$15.375 million for an internal service. "Food and Drink" expenditure for the period was \$3.696 million without VJH expenditure, at most VJH expenditures would have matched those of KPH. Thus, at most the total of \$22.967 million for an internal service is substantially less than the \$35.834 million payment to the contractor. The seemingly high payments to the contractor highlight the major concerns with this contract and the need on both qualitative and quantitative grounds for its review.
- Cleaning & portering - \$40.361 million for an internal service compared to the contract sum for 1997/98 of \$31 million.

Thus, divestment apparently saved money in cleaning and portering, but increased costs for dietary services at KPH and VJH.

**TABLE 2.5. EVALUATION SUMMARY OF DIVESTMENT PROGRAMME -
KINGSTON PUBLIC HOSPITAL**

Service	Service impact/cost before Divestment	Service impact/cost after Divestment	Remarks
Janitorial & Portering	Aggressive union activity and bureaucratic red tape made application of sanctions difficult. Little control over additional costs for overtime, vacation leave and other staff costs.	Hospital cleaner. Spills cleaned promptly, garbage collection smooth. Patients pleased with change. Rat and roach infestation tackled successfully.	The “hidden” personnel cost now borne by contractor. Reduced number of transactions relating to personnel management. Result in improved service to staff.
Cost		\$31.473 million	
Security	Fear. Difficulty in scheduling staff to work at night.	Staff has good feelings about safety. Reduction in reported cases of abuse of staff by patients’ relatives.	
Cost		\$11.997 million	
Dietary	Same as for Janitorial service	Plethora of complaints – late, cold and spoiled meals.	Important that priority be shifted to commissioning the new kitchen.
Cost		\$35.834 million	

2.8 Cornwall Regional Hospital

Cornwall Regional Hospital (CRH) is a Type A multi-disciplinary hospital located in the tourism Mecca of the Caribbean, Montego Bay. It provides specialist referral services to all of western Jamaica in most of the specialties and a number of sub specialties including Anesthetics, Ophthalmology and ENT. It has a bed capacity of four hundred & thirty five but due the shortage of trained nursing staff currently operates only 350 and these have occupancy rates close to 100%.

The administration and staff appear to be satisfied with their internal arrangements for security and indicated no interest in divesting the service. However, the physical layout of the institution presents a serious challenge for janitorial and portering services, the only service to have been divested to date.

Aggressive union activity and hence the difficulty to control the hidden personnel costs of absenteeism, lateness and overtime provided the influence to contracting out the service. All categories of staff with which we came in contact were pleased with the results in the inpatient

care areas. The wards, bathrooms and all areas adjacent to them were clean, spills were removed quickly and generally “things were much better than before divestment”.

Reports were that the staff had no idea about the “finer” points of caring - lifting patients, the correct way to dust and clean surfaces, transferring patients from trolleys to bed and vice versa, etc., – because of a lack of orientation and training. Additionally, supervision by the contractor was deficient at night and on weekends. This combination placed an added burden on Nursing administration in terms of having to supervise them on the wards.

“The contractor just cannot clean and polish the first to third floors as was done before divestment”. This is a major problem to the remaining staff as the claim is that the polish used by the contractor cannot withstand the heavy traffic in the area - out patient services, hospital and primary care administration, among others.

The contract price for 1997/98 was \$1.383 million per month - \$16.596 million . The staff numbers providing the service prior to divestment was 88 and for salary and wages only at 97/98 level is \$16.913 million . See Table 2.6.

TABLE 2.6. EVALUATION SUMMARY OF DIVESTMENT PROGRAMME - CORNWALL REGIONAL HOSPITAL

Service	Service impact/cost Before Divestment	Service impact/cost after Divestment	Remarks
Janitorial & Portering	Bureaucratic red tape made application of sanctions difficult. Little control over additional costs for overtime, vacation leave and other staff costs.	Hospital In-patient care areas cleaner. Poor supervision at night and on week ends. Contractor not training staff. Paying low salaries hence high staff turnover.	The “hidden” personnel cost now borne by contractor
Cost	\$16.913 million. – Salary costs only.	\$16.596 million	Significant savings when cost of cleaning materials added.

2.9 Bustamante Hospital For Children

Since its inception in November 6, 1963, the Bustamante Hospital for Children remains the only Pediatric Specialist facility of its kind in the English-speaking Caribbean. Extensive redevelopment was initiated in May 1988. New buildings and equipment were acquired for Accident and Emergency, Outpatient, Radiology and Laboratory Departments. An Operating Room suite, a high risk Neonatal Nursery, three Medical and two Surgical Wards, as well as a new Service block to accommodate the Morgue and Maintenance Workshop, were also included.

The hospital is the main center for sick children up to ten years of age with cases being referred from all parts of the island. An average of 40,000 patients are seen annually in the Emergency Department which is staffed 24 hours daily, and over 20,000 patients seen at the Outpatient Department.

Two support services have been divested: security and portering/cleaning. Very serious concerns have been expressed about the quality of the portering/catering service provided by the present contractor to the extent that the administration has recommended termination of the contract on non-performance grounds (see Table 2.7).

Although no historical costs were available, the evaluators estimated the cost of an internal security service comparable to the divested service. It was assumed that internal staff would receive a base salary comparable to that of a driver, about J\$5000 per fortnight. The cost of an internal service was increased by an estimated 52 paid days off per year (10 holidays, 14 vacation days, 14 sick days, and 10 days of departmental leave), as well as shift premiums allowance, supper and taxi allowance, and uniforms. The base contract rate of J\$78.5 per hour for an unarmed guard was paid only for hours actually worked. The divested service is 36% less than the cost of a comparable internal service. The number of contract security staff (7 to 8 on duty at all times, 24 hours per day, 7 days per week) probably exceeds the number that would have been hired internally, however. Thus, the cash savings is likely less than this calculated “savings” for a comparable service.

TABLE 2.7. EVALUATION SUMMARY OF DIVESTMENT PROGRAMME - BUSTAMANTE CHILDRENS HOSPITAL

Service	Service impact/cost Before Divestment	Service impact/cost after Divestment	Remarks
Janitorial & Portering	Aggressive union activities and bureaucratic red tape made application of sanctions difficult. Little control over additional costs for overtime, vacation leave and other staff costs.	Hospital cleaner but the effort of staff to “chase” contractor, intolerable.	The “hidden” personnel costs now borne by contractor.
Security	Occasional incidents.	Very professional service	Improvement
Cost	Estimated 1998 cost for an internal service J\$ 10.2 million	Projected 1998 contract cost is J \$6.5 million	Divestment saved 36% compared to divested service.

2.10 Conclusions

There is no doubt that there is strong support for the divestment program in a majority of the hospitals studied. The administrative and nursing staff are convinced that:

- the hospital plant and grounds have been enhanced;
- patient satisfaction is at a much higher level than before divestment; and generally,
- health care delivery has improved to the extent that it is now attracting patients away from

the private health sector and assisting in cost recovery.

The exceptions are: Bustamante Hospital, a qualification of the support to in-patient services only at Cornwall Regional Hospital, and the dietary service at Kingston Public Hospital where the need to review the priority weighting on the construction of their new kitchen facilities.

The program's impact on employment serving public facilities was minimal. The government specified the numbers of staff the contractor could employ to carry out the functions under the contract, and these numbers were more or less in line with the cadre prior to divestment. However, quite appropriately, the program also had an impact in private sector. A number of small firms employing a significant number of persons sprang up to provide janitorial services for the branches of banks and near banks, shopping centers and malls located in the urban centers of the island. It should be noted that the private sector also had its share of down sizing, and it is the evaluators' view that the number of staff employed by these janitorial firms to perform cleaning and janitorial services exceeds the number lost from private sector firms performing the same functions. This observation, however, needs hard data and further study."

The cost effectiveness of the program in all hospitals could not be accurately determined because of the paucity of hard financial data for the period prior to divestment. Nevertheless, the significant hike in public sector wages over the last two salary negotiating periods (1994/96 and 1996/98) has made the salaries component of the service provided in-house higher than the current cost of the contracted services. This was shown at Savanna la Mar, CRH and KPH/VJH (Unpublished data from Valerie James, CEO, Jennifer Barton-Campbell, Dietician, and Chris Morris, Site Manager, Dual Security Services, August, 1998). The level of the discrepancy at the Kingston complex raises other questions about staffing cadres.

3. COST RECOVERY

3.1 Background and Purpose

The cost recovery component of the evaluation focused on several generic questions:

- *What strategies are being used by individual hospitals to recover fees?*
- *What factors contribute to higher recovery rates?*
- *What conditions encourage low recovery rates?*
- *What is the process, structure, and outcome of the different functions of the fee collection process?*
- *What are the record keeping mechanisms used by individual hospitals? How much variation is there?*
- *In what ways are patients communicated information about fees?*
- *What type of staff are involved in the fee collection process? At what level (e.g. setting policies, approving exemptions, collecting deposits, etc.)*
- *What facets of the fee collection process are computerized?*
- *If computerized data are generated, how much is aggregate (e.g., total amount owed by all patients at a given time, total amount exempted by month and by category) or disaggregated (e.g., total amount paid and owed by an individual patient for a particular hospital stay).*

- *Were there any social marketing impacts?*

3.2 Methods

Both primary and secondary data sources of data were collected to base findings about the Cost Recovery component of the Health Sector Initiatives Program (HSIP) in Jamaica. Primary information was collected through individual site visits of seven hospitals during the period August 10-17, 1998:

- *Mandeville Hospital*
- *May Pen Hospital*
- *Spanish Town Hospital*
- *Savanna-la-Mar Hospital*
- *Noel Holmes Hospital*
- *Cornwall Regional Hospital*
- *St. Ann Bay Hospital*

Interviews were made with key HSIP staff, hospital staff, beneficiaries (inpatient and outpatient), and relevant representatives of USAID, Ministry of Health, etc. Input from the Regional Directors was gathered in a group forum.

The Health Finance Specialist and the Team Leader also reviewed secondary cost data. Data included cost recovery data by hospital, forms and guidelines used in determining and collecting fees, computerized systems and data maintained, etc. In addition, selective information provided by the Ministry of Health staff was also reviewed.

Hospitals selected for the onsite visits were based either on the type of hospital (class A, B, or C) and rate of fees collected (some hospitals had the highest and some had the lowest rate of collection). A hospital from at least each of the four regions was selected. For efficiency purposes, hospitals were also selected if they had divested some services, so that cost recovery and divestment could be evaluated in parallel. Because of time constraints, the visit to Noel Holmes (which had no divested services) was limited to a qualitative analysis.

At each hospital selected for a quantitative analysis, a systematic sample of approximately 24 inpatient admissions during the 1997-98 fiscal year was selected. In most hospitals, this sample was gathered by selecting two random days of the month, and then randomly selecting a patient admitted on the chosen date. For each selected invoice, the evaluators gathered the charges for the hospital admission, and the amount collected to date from the patient (or insurance). In several hospitals, the amount collected was subdivided into the part received prior the patient's discharge from the hospital, and after the discharge. As this sample was small and charges and collections were quite variable, the results were validated against aggregate collections, as described below.

Outpatient invoices tended to be smaller and less variable. The evaluators interviewed the staff in Spanish Town to ascertain the pattern of outpatient charges and collections per visit. These results were extrapolated to the other hospitals for which detailed data could not be obtained in the time available. Finally, the sample numbers were extrapolated, based on known numbers of inpatient admissions and ambulatory visits from the Health Information Unit, to the entire year's activities.

Lastly, the estimated inpatient and ambulatory fees collected were summed and compared against the amounts actually reported to the HSIP finance coordinator. In 5 of the 7 hospitals with quantitative analysis, the two agreed within 5%. In two hospitals, the small samples were considered unrepresentative, and the sample collections were adjusted. In Sav la Mar, where the sample collection rate appeared unusually high (74%), the rate was adjusted downwards to 60% of the small sample estimate. In St. Ann's Bay, where the rate seemed unusually low for the careful procedures and substantial income generated, the sample rate was doubled (from 27% to 54%).

3.3 Impact on access

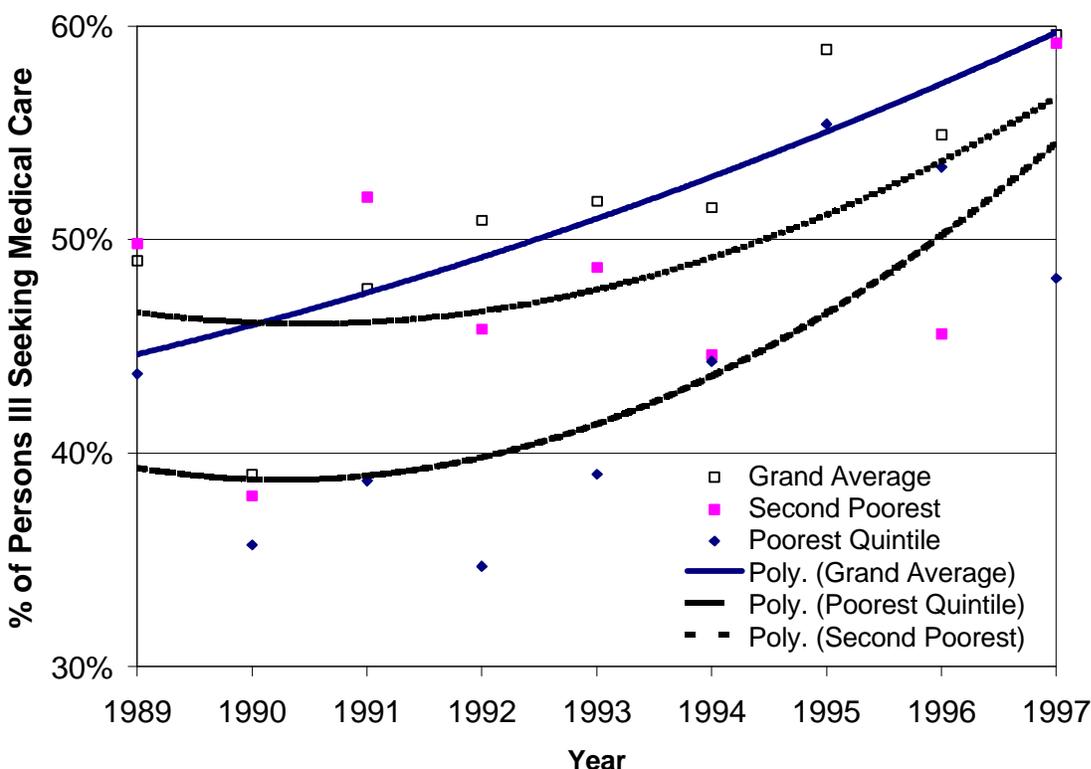
One of the concerns about cost recovery is that it would impair access to health services, especially among the poor. Both academics and politicians have expressed this concern. Indeed, in Jamaica, reports since the 1980s by the Ministry of Health and various international donors, including USAID and the World Bank, have shown the rationality of higher user fees for curative health services (Cumper, 1993). As this evaluation shows, a decade later implementation has been slow, largely due to this concern.

Fortunately, Jamaica has a rich source of data that allows the impact of higher user fees to be assessed empirically, the Survey of Living Conditions (1997). Beginning in 1993, the Ministry of Health raised the fees for services in most ambulatory facilities to J\$50 for registration and J\$50 for a prescription, regardless of the number of items. Previously, the fee had been J\$5 – a level that had been set many years earlier, when the Jamaican dollar had substantial greater purchasing power. The annual survey of living conditions has obtained data on randomly chosen samples of Jamaicans since 1989. The 1976 survey analyzed data from 1824 households containing 7004 household members.

The Survey of Living Conditions asks respondents whether they were ill in a 4-week reference period preceding the survey and, if so, whether they sought medical services. One important indicator of access is the proportion of ill persons who sought services. Although there are a number of factors that govern the decision to use services, changes in use from one year to the next are an indicator of the degree of geographical, financial, and convenience access in the public and private sector combined.

Annual data are variable because responses are based only on the 10% subset of persons who were ill in the past 4 weeks. Thus, trend lines (termed polynomials of degree 2) were fit over the 9 years from 1989 through 1997. Three separate trend lines were fit: the grand average for all respondents, as well as one for the poorest and second poorest quintiles (in terms of overall per capital consumption). Figure 3.1 reports the result of this analysis. The results show an upward trend line over the entire period for the grand average of all economic groups, and upward sloping trends lines since 1991 for the two poorest economic groups. Thus, despite official rises in public sector prices, and substantial increases in private sector prices, overall access to medical care has been maintained in Jamaica over the past decade.

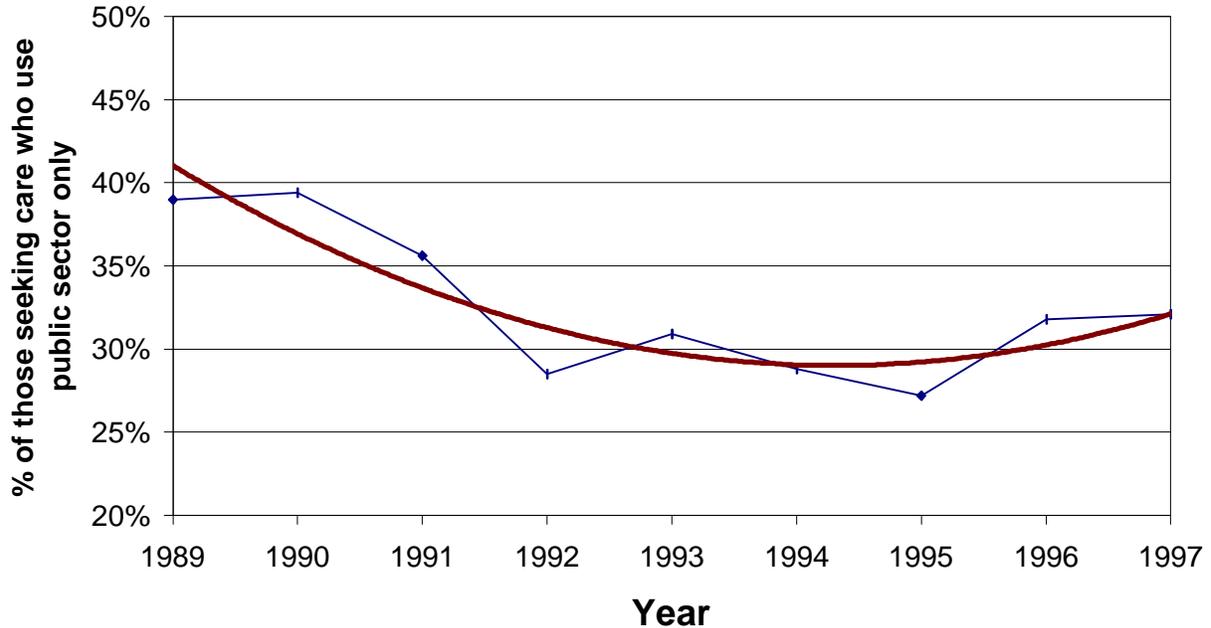
Figure 3.1. Access to Medical Care by Economic Quintile



A second measure of access to the public sector is the share of persons seeking medical care who chose the public sector. A person could seek care in the public sector, the private sector, or both (and in either order). Despite increases in user fees, the public sector remains less expensive than the private sector. If the public sector is adequate in quality (in technical, interpersonal, and schedule components), those in need are more likely to use it. Thus, the proportion of those seeking care only in the public sector is an important indicator of the quality of that sector.

Figure 3.2 shows both the annual raw data and the trend line (also a polynomial of degree 2). The proportion of respondents using only the public sector declined from 1989 through 1994. This trend could reflect deterioration in the public sector and/or adequate income for private services. Despite the increase in user fees that began in 1993, the share using the public sector has increased slightly. One of the interpretations of this pattern is that price increases since 1993 have not proved a barrier to access.

Fig. 3.2 Choice of public sector among those seeking medical care



3.4 Procedures for cost recovery

Tables 3.1 through 3.3 describe the procedures for cost recovery in each hospital visited by the team. Particularly important are the procedures for requesting payment. For example, the most successful procedures (used at May Pen and Savanna la Mar), informed patients of the probable or actual charges for their inpatient care at three times during their stay:

- (a) on, or within a day of admission, when they were asked to make a partial payment (at Sav la Mar, covering 5 days accommodation fees),
- (b) at interim points every 2-3 days during their stay, when patients were informed about costs incurred to date for drugs, lab tests, operating theater, and accommodations,
- (c) at discharge, when an actual bill was computed, and patients were asked to pay the balance owed, or as much as possible of it.

Finally, patients received an additional notification after discharge, when bills were mailed showing any remaining outstanding balance.

The last step proved to be considerable effort with a low yield. Several hospital staff reported a culture in Jamaica that government services are supposed to be free. Thus, patients would often give a false name or address to hospitals (and to other government agencies), so many bills were returned undeliverable. Of those that did reach the patient, many were ignored. Only a few hospitals had sufficiently well maintained records to even know whether a patient had an

outstanding balance from previous treatment when the patient returned. Even when that existed, laws and ethical standards prevented the hospital staff from denying care.

Several conclusions can be made about the primary and secondary collected concerning the cost recovery program. First, as shown in Tables 3.1 through 3.3, there is across the board variation among hospitals in both process and structure of the fee collection process. For example, although most hospitals have an assessment function as part of their fee collection process, some hospitals have dedicated staff performing only this function while other hospitals have added these necessary but demanding responsibilities to current duties (like clerical or medical records). Staff having multiple responsibilities that oftentimes are under separate departments places time constraints on what they can do and which tasks are a priority. However, staff who do both cashiering and assessment tended to understand the importance of their work to the fee collection process.

Hospitals also tend to vary in the level of detail maintained through record keeping mechanisms. At minimum, all hospitals kept two documents: Cash Receipts Log and a Fee Breakdown Sheet (given by each cashier to the main cashier at the end of his/her shift). Although hospital staff received formal training on what documents are to be maintained, there was no consistency among hospitals beyond these two documents. For example, one hospital maintained a yellow billing card on each hospital while the rest did not. Only half of the hospitals kept an exemption log.

Many hospitals tended to have their fee collection process manually performed. Two hospitals were computerized but could not figure out how to generate data on total amount using the computer (instead this information was calculated manually), or either had not been trained to understand what financial information could be generated by patient and in the aggregate. Another hospital received the computer hardware (but no software) and did not know what was expected of them in terms of computerizing the fee collection process.

Hospitals that had higher recovery rates tended to implement the following collection procedures: They required some amount of deposit at the time of admission, interim payments during a hospital stay, and balance paid-in-full upon discharge. If the balance was not paid in full, these hospitals tended to have an aggressive mailing process and a monitoring process. A copy of the invoice was placed with the medical records so that any late or missing payments were brought to the attention of the patient at their next inpatient or outpatient visit. Another significant factor that contributed to higher recovery rates was the involvement of the CEO in the collection process. For example, the CEO of the hospital that had a relatively high collection rate was very involved in monitoring exemption amounts and rates, cash collected, and met personally with problematic patients who refused to pay hospital fees.

Table 3.1.: Cost Recovery Procedures in Selected Hospitals: Part 1.
Hospitals Visited

Attribute	Mandeville Hospital	May Pen Hospital	Spanish Town Hospital	Savanna-la-Mar Hospital	Noel Holmes Hospital	Cornwall Regional Hospital	St. Ann Bay Hospital
Assessment Function							
<i>Primary Role</i>	Assess patient's ability to pay upon request for exemption or questions	Assess patient's ability to pay; processes bills; and determines exemptions	Assess patient's ability to pay; processes bills; and determines exemptions	Assess patient's ability to pay; processes bills; and determines exemptions	Processes patient's bill	Assess patient's ability to pay; processes bills; and determines exemptions	Assess patient's ability to pay; processes bills
<i>Structure</i>							
No. of Dedicated Staff	2	1	2	2 clerical staff are assigned the assessment role	1 medical records person is assigned the assessment role	5	6 cashiers are assigned the assessment role
Dedicated Space	Yes	Yes	Shared with Cashiers	Yes	No	Yes	Desk space in medical records dept.
Uniforms	No	No	No	Yes	No	Yes	Yes
Hours Available	24 hours	24 hours (cashier backup)	8:30a.m.-5p.m. (Mon.-Fri.)	8:30a.m.-5p.m. (Mon.-Fri.)	8:00a.m.-5p.m. (Mon.-Fri.)	8:00a.m.-5p.m. 2-10p.m (7 days a week)	6:30a.m.-2:30p.m. 1:30-10p.m. 10p.m.-6:30a.m. (7 days a week)
<i>Process</i>							
Organizational Location	Separate dept. which oversees the cashiering function	Separate dept. which monitors the cashiering function	Separate dept. which oversees the cashiering function	Separate dept. from the cashiering function	Part of the medical records dept.	Part of the Patient Affairs Dept.	Part of the medical records dept.
Record keeping Mechanisms	Invoice log Triplicate invoices Insurance log Exemption log	Computerized (Heron) invoices when over J\$50 outstanding; Insurance in Heron; Exemption log	Patient Cards Invoice Log Insurance Log Exemption Log	Insurance Log Exemption Log	None	Medical Bill Log Exemption Log Insurance Log	Medical Bill Log
Verification of Work	None	None	None	None	None	Manager, Patient Affairs	None

Table 3.2. Cost Recovery Procedures in Selected Hospitals: Part 2.

Hospitals Visited

Attribute	Mandeville Hospital	May Pen Hospital	Spanish Town Hospital	Savanna-la-Mar Hospital	Noel Holmes Hospital	Cornwall Regional Hospital	St. Ann Bay Hospital
Cashiering Function							
<i>Structure</i>							
No. of Dedicated Staff	6 Sub-Cashiers 1 Main Cashier	4 Sub-Cashiers 1 Main Cashier	2 Sub-Cashiers 1 Main Cashier	3 Sub-Cashiers 1 Main Cashier	1 Sub-Cashier 1 Main Cashier (Finance Dept.)	8 Sub-Cashiers 1 Main Cashier (Finance Dept.)	6 Sub-Cashiers 1 Main Cashier (Finance Dept.)
Dedicated Space	Yes	Yes	Shared with Assessment Officers	Yes	Desk space in medical records dept.	Yes	Desk space in medical records dept.
Uniforms	Yes	From Sept 98	Yes	No	No	Yes	Yes
Hours Available	24 hours	24 hours	8:30a.m.-5p.m. (Mon.-Fri.)	7 a.m. - 3 p.m. 2 p.m. - 10 p.m. 8 a.m. - 4 p. m. (7 days a week)	8:00a.m.-5p.m. (Mon.-Fri.)	7a.m.-3p.m. 2-10p.m. 10p.m.-7a.m. (7 days a week)	6:30a.m.-2:30p.m. 1:30-10p.m. 10p.m.-6:30a.m. (7 days a week)
<i>Process</i>							
Organizational Location	Under Assessment Dept.	Under Accounting Dept.	Under Assessment Dept.	Under Finance Dept.	Under Medical Records Dept.	Under Patient Affairs Dept.	Under Medical Records Dept.
Record keeping Mechanisms	Receipts log Revenue book Lodgment book	Receipt book; Revenue book, Lodgment book; Patient bills in docket	Two Documents: Cash Receipts Log Fee Breakdown	Five Documents: Cashier/ Assessment Log Cash Receipts Log Outpatient Exemption Log Elderly Receipt Log Fee Breakdown	Two Documents: Cash Receipts Log Fee Breakdown	Two Documents: Cash Receipts Log Fee Breakdown	Two Documents: Cash Receipts Log Fee Breakdown
Verification	Main cashier and accountant	Main Cashier	Main Cashier	Main Cashier	Supervisor, Medical Records	Main Cashier	Main Cashier

Table 3.3. Cost Recovery Procedures in Selected Hospitals: Part 3
Hospitals Visited

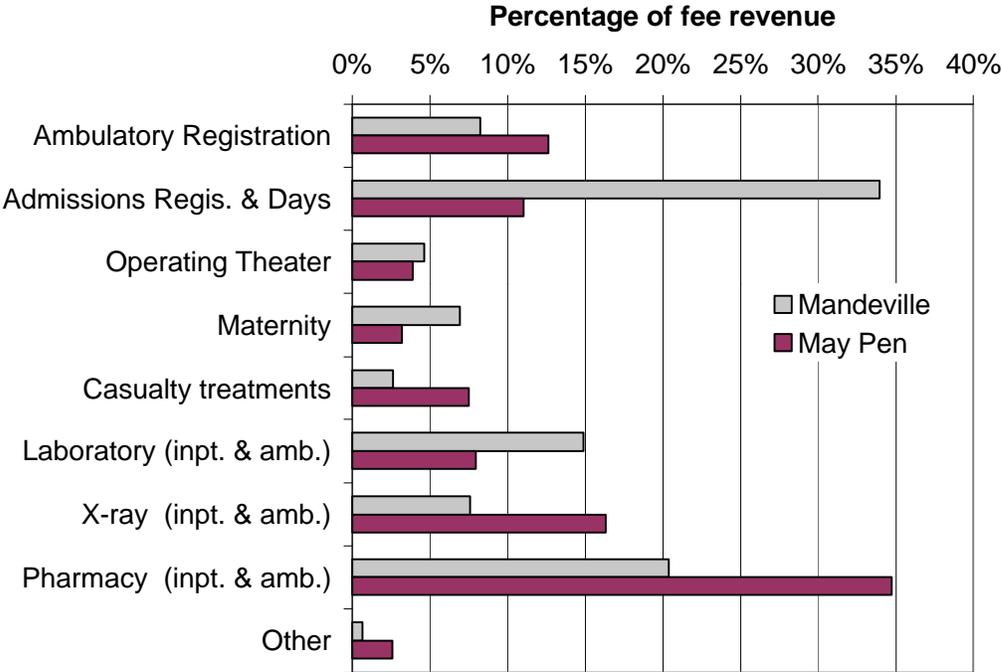
Attribute	Mandeville Hospital	May Pen Hospital	Spanish Town Hospital	Savanna-la-mar Hospital	Noel Holmes Hospital	Cornwall Regional Hospital	St. Ann Bay Hospital
Fee Collection Process							
Computerized	Has hardware and patient administration system; staff being trained. Began Dec 97, now generating fees	Operating Heron patient administrative system since Nov. 97 (admissions and discharges) and outstanding fees since Mar 98.	Has hardware only from the MOH. No software and training has been given. Hospital does not have space to accommodate computer.	None	None	Has hardware only from the MOH. No software and training has been given.	Has hardware and software for the admission and medical records function. Module is available to accommodate fees but software is not working properly.
Who Prepares Patient Bill	Assessment Officers	Assessment Officers	Assessment Officers	Assessment Officers	Medical Records Person	Assessment Officers	Cashiers
When Patient Receives Bill	Last day of admission	Approximate bill on admission; updates every 2 days	Last day of admission	Last day of admission	During admission (estimated bill); at discharge (adjusted bill)	Last day of admission	Last day of admission; after discharge
Copies of Bill	Patient (original); docket (copy); invoice book (copy)	Handwritten original in docket; computer copy to pt with unpaid balance	Patient (original); medical records (copy)	Patient (original); medical records (copy)	Patient (original); medical records (copy)	Patient (original); medical records (copy)	Patient (original); medical records (copy)
Deposit Required	No	Requested and expected	Yes--amount varies	Yes--amount varies	Yes--amount varies	Yes--amount varies	No
Communication to Patients About Fees	Forewarned at admission; All explained at discharge; More difficult patients at admission	Nurse in ante-natal clinic, surgical patients referred in advance to assessment officer; medical on admission	All elective admissions; at discharge; after discharge	All elective admissions; at discharge; after discharge	All elective admissions; during admissions	All elective admissions; at discharge; after discharge	All elective admissions; at discharge; after discharge
Involvement of CEO	Confer with difficult patients, discuss about exemptions; discussions with politicians	CEO asks weekly and monthly collections, exemptions, insurance, and projected revenues	None	Monitors exemption policy; meets with problematic patients; monitors cash collected	Checks the Revenue Cash Book (instead of an accountant)	Reviews fee structure	Approves exemptions (along with accountant or administrator); reviews fee structure

3.5 Level of cost recovery

Hospitals charge fees for both ambulatory and inpatient care. For ambulatory care, fees are charged for registration (the professional visit, both casualty and specialty outpatient clinics), pharmacy (for ambulatory prescriptions), treatments (such as injections and dressings), and diagnostic services (laboratory and X-ray). For inpatient care, fees are charged for admission, daily accommodation, operating theater, maternity pharmacy, treatments, and diagnostic services. Fees are also charged for completion of certain certificates.

While the Ministry of Health theoretically sets standard fees for all hospitals, in practice hospital boards and Chief Executive Officers have adapted them to local circumstances. Figure 3.3 shows the fees at two study hospitals that maintained clear breakdowns of fee revenue by source. While there is some variation among hospitals, several results held across all hospitals. While the registration fees (typically \$50 for an ambulatory visit, and about \$150 per day for accommodation) are the most visible fee, they are not the services which generated the most revenue. The combined charges of pharmacy, laboratory, and X-ray tended to be far higher. While Operating Theater charges applied only to surgical inpatients, this service generated the highest amounts, about J\$3200 for a Major B procedure. When ambulatory patients requested exemptions for fees because they were unable to pay, pharmacy and laboratory charges were the services needing exemption more than registration fees. It was these services which tended to be higher on average, and highest overall.

Figure 3.3. Breakdown of Fee Revenue at Two Hospitals

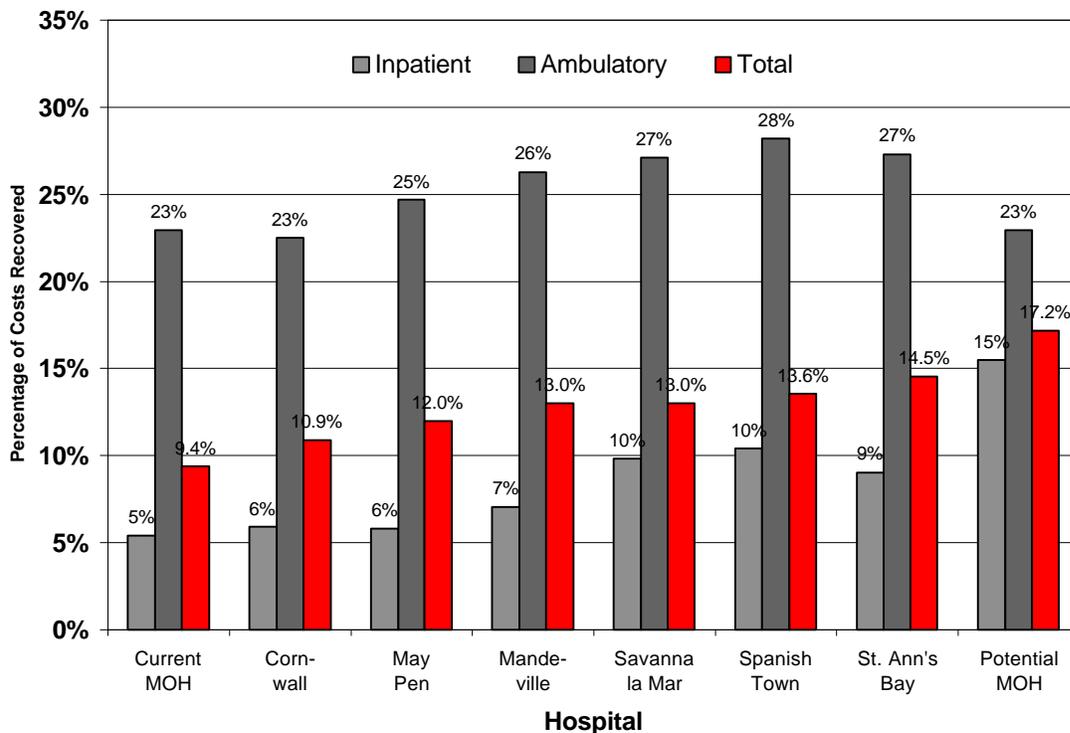


The evaluators were unable to obtain systematic aggregate data on the amount of exemptions for ambulatory services in relation to the amounts charged. The limited data, however, suggested

that only 20% of ambulatory patients were formally exempted. The Ministry’s current study of the use of services by indigent patients should provide information in the future.

As inpatient and ambulatory services varied in their approach to collection, the degree of cost recovery varied accordingly. In general, patients were required to pay for ambulatory visits, prescriptions, and laboratory services before receiving the service in question. A flow pattern was established and receipts were issued and examined to ensure adherence. By contrast, no advance payments were required (and sometimes not even requested) for inpatient services. In addition, the fees for inpatient services, even if collected in full, would cover only a small fraction of the cost of the services received. Figure 3.4 shows the comparative cost recovery for inpatient and ambulatory services by hospital for the 1997/98 fiscal year.

Figure 3.4. Comparative Cost Recovery: Inpatient vs. Ambulatory



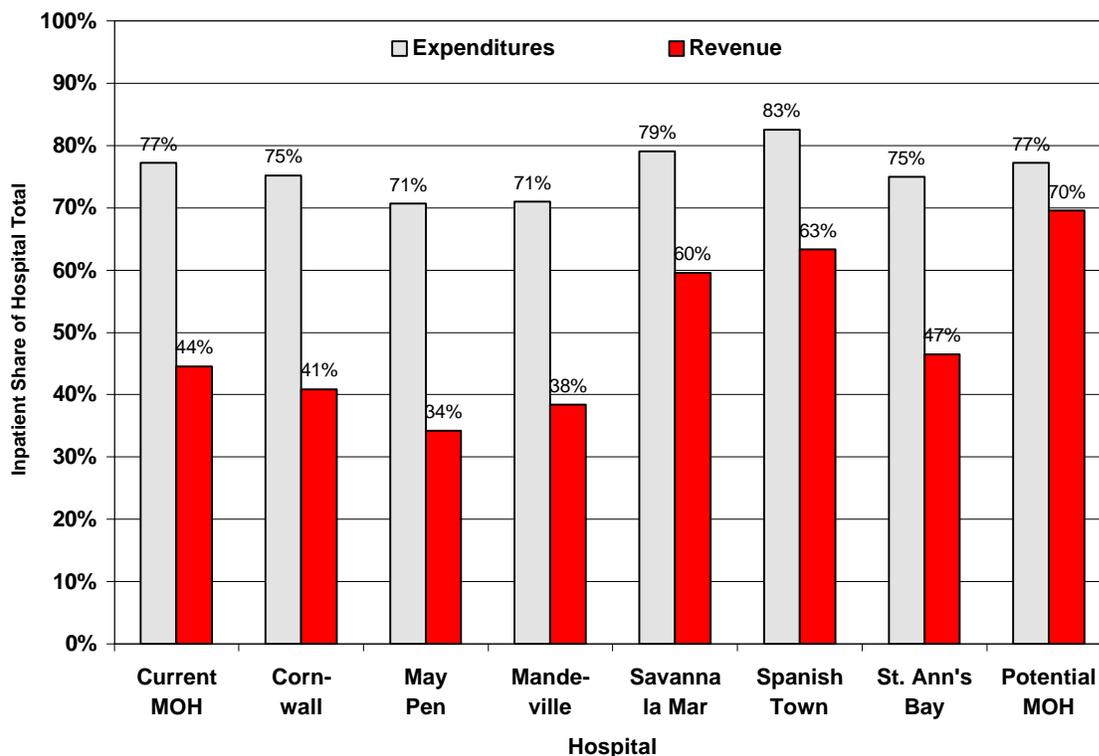
Extrapolating from the study hospitals to all MOH hospitals, the evaluation team estimated that fees recovered only 5% of the cost of inpatient services, 23% of ambulatory services, and 9.4% overall. The percentage cost recovery are based on the amount received (J\$248.5 million for the MOH overall) as a percentage of the evaluation team’s estimate of the operating costs of the hospital or MOH during the year. The evaluation team’s estimate is the “revised estimates” in the budget reduced by 10 percent. The 10 percent reduction is applied because the “revised estimates” include salary adjustments for government workers both for the 1997/98 fiscal year, as well as a retroactive adjustment for the preceding fiscal year. The 10 percent adjustment is the approximate amount attributable to the retroactive adjustment. For the MOH overall the evaluation team’s estimate is J\$2,942.9 million less 10 percent, or J\$2648.81 million. For the

MOH overall, the actual expenditure in the preceding year was J\$2478.60. It was lower than evaluation team’s estimate for the 1997/78 year, as expected.

The “Potential MOH” bars in Figure 3.4, based on further analyses below, show the degrees of cost recovery that would be obtained if the rate of collections were optimal. The optimal level assumes the current fee schedule, averaged across study hospitals for inpatient services, the Spanish Town schedule for ambulatory services, and 20% exemptions for both ambulatory and inpatient services. Under this optimal schedule, only about 15% of inpatient costs could be recovered. The current 23% of outpatient costs is already optimal. Overall, about 17.2% of hospital costs would be recovered. While this is almost twice the current level of 9.4%, it is still below the target of 20 percent set in 1993 for the HSIP.

Given the importance of inpatient fees in increasing cost recovery, Figure 3.5 examines the pattern by hospital. The figure shows that inpatient services represent 77% of the costs of MOH hospitals overall, but only 44% of the revenues. While the share of hospital costs for inpatient services varies little by hospital, the share of revenues varies substantially. Sav la Mar, with higher charges and relatively low costs, had one of the highest shares of revenue derived from inpatient services (60%). The MOH potential, with optimal collections, would generate 70% of revenues from inpatient services, still less than its 77% share of costs.

Figure 3.5. Inpatient Share of Expenditures vs. Revenues



The low degree of cost recovery for inpatient services is due to both low fees and low collection of these fees. Figure 3.6 separates these two factors, by hospital, with detailed data in Appendix B. An average inpatient admission (with a 6.4 day stay) in the six study hospitals cost J\$13,283. The average inpatient was billed only J\$1,773, or only 13% of this amount. The average amount

collected was only J\$778, or 6% of the cost. Thus the government subsidy of 94% of cost is the sum of bad debt (unpaid fees, 6% of costs) and planned subsidy (87% of costs) for patients officially exempted, and fees that represent only a small fraction of costs.

Figure 3.6. Financing of an Average Inpatient Admission, 1997-98

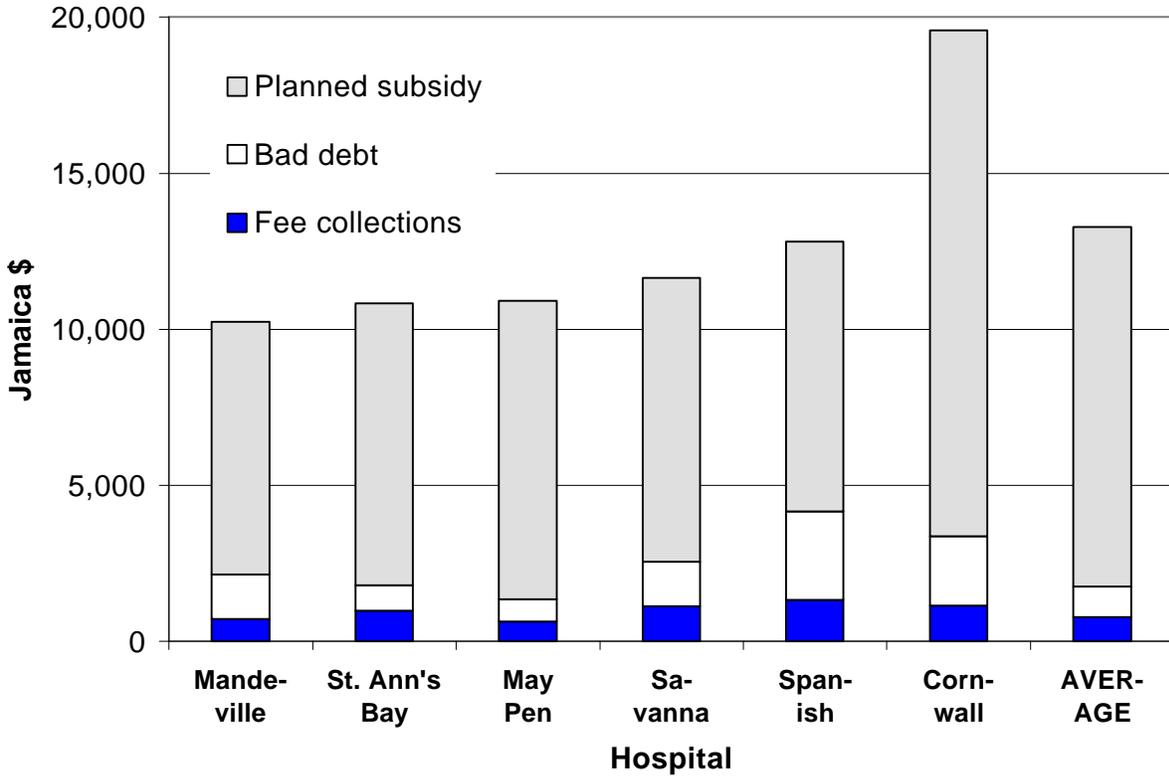
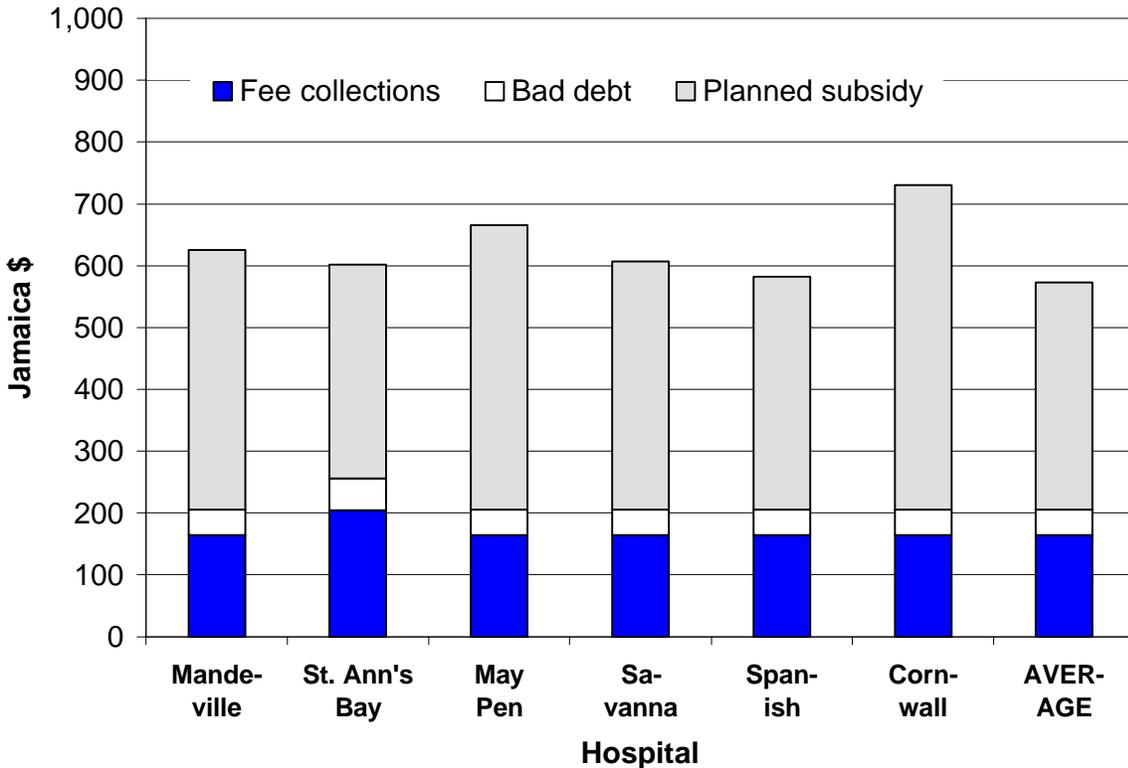


Figure 3.7 presents a comparable breakdown of the financing of an ambulatory visit. The average cost of a visit is J\$573. Again, tabular data are in Appendix B. The pattern differs from that for inpatient care in several ways. First, fee collections are a much higher share (29%) of costs. Second, bad debt is relatively small (7%) compared to the above mentioned fee collections (29%). Thus, the planned subsidy for ambulatory services (64%) is much less than that for inpatient services (87%).

Figure 3.7. Financing of an Average Ambulatory Visit, 1997-98



3.6 Recommendations

A major accomplishment of the cost recovery program has been establishing an expectation that patients must pay a share of the cost of their hospital treatment. Several missed opportunities still exist in hospitals to fully implement cost recovery procedures and records and to closely monitor ways to improve their cost recovery rates. It is recommended that the MOH ensure that procedures and standards for cost recovery are established. The Regional Authorities should see that they are followed and maintained among all hospitals within their region. The procedures and standards are generally acceptable already, but the implementation is inconsistent and the fees schedules are too low. The oversight should also include frequent onsite visits of each hospital so that appropriate guidance and support can be given by the Fiscal Coordinator, MOH, and the Regional Directors. Both need to work in tandem to maximize favorable intended and unintended effects of the cost recovery program.

It is imperative that the CEO of each hospital is actively involved in the cost recovery program. The CEO is uniquely positioned to ensure that each staff member understands how his or her work contributed to the “big picture” of a financially solvent and quality hospital. Thus, staff would appreciate the need, for example, to generate aggregate data on total amount billed or the opportunity cost associated with approving each exemption. Therefore, it is recommended that CEOs be held more accountable in ensuring that standards and procedures of the cost recovery program are properly implemented. At minimum, CEOs should do the following:

- Write an Exemption Policy for the hospital that lists criteria or situations when exemptions are to occur. The policy should identify what documents are to be maintained, who are to maintain them, and which hospital staff members are to approve exemptions. Since a precedent has already been set in some hospitals, it is recommended that an Exemption Log be required by all hospitals. The Exemption Log should correctly lists all exemptions (i.e., name of patient or employee, amount exempted, date, reason for exemption). It is highly desirable that CEOs approve all exemptions and that a hospital senior staff person be designated to act in his/her absence so that the patient or employee does not have to wait for a decision.
- Meet with problematic patients who are unwilling to pay fees so that patients are educated about how revenues generated from fees are spent and how they individually benefit if they were to purchase, for example, prescribed drugs on the open market.
- Confer monthly with the finance staff about the status and trends in “accounts receivable” from patients.
- Review on a periodic basis the fee structure of the hospital and modify to be consistent with the parameters set by the MOH and reflective of what the “local market” can bear. The Regional Directors should review the fee schedule of each hospital within their jurisdiction so that fees are somewhat consistent if deemed necessary. For information purposes, fee structures of each region should also be shared among the four Regional Directors.

However, in order for CEOs to really “buy into” the goals of the cost recovery program, MOH should establish incentives that generate institutional benefits to each CEO’s hospital. These guidelines should be formalized under a new program called “Revenue Retention”. Under this Revenue Retention Program, hospitals should be allowed to keep some portion of the fees collected as discretionary funds, without the additional revenues reducing the subsidy from the Ministry Finance, and without requiring approval for the use of these funds. A reasonable revenue retention figure of 25% or \$0.25 on every \$1 in fees collected could be the starting point. Thus, these discretionary funds should be an add-on to a hospital’s approved budget from the MOH rather than a subtraction from the government subsidy.

A number of other promising strategies can be considered to improve cost recovery:

- Local autonomy. The Ministry of Health has tolerated the adapting of user fee schedules to local market conditions for an individual hospital. This practice should be formalized by giving Regional Directors formal authority over fees in their regions. This step should help hospital administrators balance the hospital’s revenue needs against the potential (though not documented) restrictions to access or political repercussions.
- Communication about government subsidies. Most patients do not know the extent of government subsidy for health services, particularly inpatient services. We recommend that hospitals post the economic cost for each service alongside the charge. The economic cost could be either a national average, or a specific calculation for each hospital. As shown in Appendix B, these average J\$ 13,283 per inpatient day and J\$573 per ambulatory visit. Hospitals should also post, for comparison, the fees at the nearest private clinic and hospital. These tend to be comparable to the economic cost in government facilities. The hospital can then calculate the planned subsidy that each patient has received (the difference between the charge and the economic cost).

- Communication to patients about fees. Many hospitals post outpatient registration fees, and inform women in prenatal care about the charges for deliveries at the hospital. In most cases, this information has helped patients find the necessary resources. There were no instances reported to the evaluators of a backlash from being explicit about fees. It is therefore recommended that hospitals be required to formally communicate fees for inpatient and outpatient services. The medium of communication can be a circular that is handed to each patient upon his or her arrival for an inpatient stay or outpatient visit. Not only can this circular list the amount of fees associated for each treatment or service, but can list what is expected of each patient in terms of deposit, interim payments, and the need to pay the bill in full prior to discharge. It can also communicate the expectation that if the bill is not paid in full that each patient will receive an invoice in the mail reporting what is owed post-discharge. The patient will be asked to pay the remaining balance within 30 days post-discharge, and that failure to pay may jeopardize access to non-emergency care in the future.
- Recognition for payment. For a while, the HSIP distributed “share care” stickers to hospital staff, who gave them to patients who had paid their bills. Both patients and staff seemed to appreciate them, but the practice ended when the supply of stickers was exhausted. A variety of ways of recognizing patients who pay their share would be useful. The evaluators recommend that each hospital establish a formal recognition program that acknowledges patients who pay their bills in full especially upon discharge. Hospitals should have the flexibility to design such a program and choose the method for acknowledgement. The Regional Directors should establish guidelines for such a program.
- Discounts for prompt payment. In addition to stickers (or another method chosen by a hospital), discounts of 10% should be considered for each of the following financial aids: making the required deposit within one day of admission, paying the balance due by the date of discharge, and having the account from previous hospitalizations settled when the patient returns for the next episode. Clearly, providing a 10% discount to patients under these conditions gives them a direct financial benefit that may motivate them to pay their bills on time and in full.

4. DECENTRALIZATION

4.1 *Background and Approach*

The third key component of the evaluation focused on decentralization in health reform and financing. The evaluation attempted to address four issues under decentralization: (1) the organizational relationship between Head Office and the four regional authorities, (2) the status of management activities, structures, and systems initiated and accomplished to achieve decentralization in the four regions, (3) the extent to which the Ministry of Health has implemented the decentralization process as originally envisioned, and (4) the “lessons learned” from the stages of decentralization implemented to date. The evaluation looked at how resources were utilized to support decentralization objectives at three levels: the Ministry of Health, regional offices, and hospitals.

4.2 Methodology

Legislation (passed by Parliament on February 25, 1997 and promulgated by the Minister of Health on October 1, 1997) provided for the creation of four Regional Health Authorities to manage Jamaica's health services and facilities. According to the Minister of Health, "the decentralization of the management of health services is designed to facilitate the provision of cost-effective...integrated health care of an acceptable standard to the public."

The evaluation of the decentralization component therefore focused on three dimensions: (1) the *formal structure* for decentralization at each of the three levels (MOH, regional offices, and hospitals), (2) the "*change process*" that was implemented, and (3) the extent of *communication linkages and involvement of stakeholders* particularly at the Ministry and Regional levels.

Several *forms of structure* were reviewed that guided decentralization efforts: legislation, policies, procedures, and manuals. Topics of interest were administration and governance structures, management, personnel, finance, asset transfers, etc.

Given the magnitude and complexity of the decentralization component, the "*change process*" was more challenging to look at for obvious or subtle effects. It was also equally difficult to determine the change agents themselves given that the scale of change undertaken by the MOH was considerable. One impediment to change (as noted by respondents) was that some key technical officers are not in favor of the planned delegation of authority and responsibility to directors and managers at Regional and Parish levels in the health care system. In contrast, the *communication and involvement of stakeholders* was more easy to assess since this was highlighted as an issue of contention during the interview process.

The evaluation of the decentralization component was conducted from August 12 through 18, 1998. The evaluators interviewed officers at both the Regional and Ministry levels. At the regional level, the Decentralization Specialist met with all four Regional Directors, the Chief Executive Officer of a regional hospital, three functional directors (Human Resources Management, Management Information Systems and Finance) from one health region. At the Ministry of Health, the Decentralization Specialist interviewed the Director of HSIP, two members of the Health Reform Unit, the Director of the Health Reform Unit, and one of the Ministry's Legal Advisors.

The interview process for the decentralization component was limited because of time constraints and the short window of opportunity to seek and review documents and materials (especially those mentioned during the actual interviews). For example, the Ministry's constructive comments arrived just two work days before the deadline for the final draft of this evaluation. In seeking clarification, the evaluators could not reach staff of the HSIP, but fortunately were able to confer by telephone with one of the Regional Directors (Paola Arscott).

4.3 Findings

In Table 4.1, a series of "benchmark tasks" are listed which were used to assess progress on the formal steps in the process of decentralization. These tasks were drawn from both the evaluation team's experience and the MOH documents. Since 1997 when decentralization legislation was

passed by Parliament and promulgated by the Minister of Health, our review showed that some progress has been made on these benchmarks. In terms of the “completeness” of the tasks, all necessary areas of procedural and administrative change have been identified and much work seems to be “in progress.”

Further, the review shows a consistent difference in perceptions concerning “what was done and not done” between the Regional Directors and MOH Head Office officials. For example, an MOH official indicated to the Evaluation Team that the 1991 “Green Paper” on decentralization had been distributed to the Regional Directors. A Regional Director acknowledged receiving the document, but it was too broad to serve as a operational guide for the Regional Directors. Moreover, the Regional Directors found the working relationship with MOH Head Office frustrating and unproductive, and their roles and functions unclear. One example concerned the ordering of computers and office furniture for the regional authority. One regional director, responding to a request to specify her needs, researched alternative systems and submitted a detailed proposal with budget and justification. When the need to cut costs emerged, she complied by deleting the request for file cabinets. When the computers eventually arrived, they did not match the specifications requested, and budget constraints were met by reducing the number of computers, rather than file cabinets. The Regional Director felt that not only was she not receiving the necessary equipment, but also that her executive role had not been respected.

MOH officials acknowledged that problems did exist in their working relationship with the Regional Directors. According to a MOH official, “....the induction of the Regional Directors was inadequate. However they were employed at a time of development and it was made very clear to them that they were expected to be actively involved in this process. It is now obvious that this was not as successful as hoped and the process of collaboration and cooperation will have to be re-visited and emphasized.”

As shown in Table 4.1, some areas are further advanced towards completion than others. Relative to other organizational areas, the finance area was the most developed, in the sense that the necessary financial instructions and procedures had been articulated and communicated from the MOH to the hospital level. However, Asset Registers had not been completed, nor were assets transferred to the RHAs. The delays experienced are not surprising as they are the most difficult practical areas in most attempts to decentralize.

On the other hand, according to the Regional Directors, personnel policies and procedures had not been adequately prepared to guide regional implementation efforts. MOH countered that personnel policy and procedural documents had been issued to the regions. The MOH Head Office reported distributing the following personnel documents to the regions: (a) Policy Framework Document, (b) Employment policies and procedures and conditions of service for the Regional Health Authorities, (c) Handbook on Government’s financial administration and guidelines to functions delegated by the Ministry of Finance and Planning, (d) Instruments of Delegation to Regional Authorities, and (e) Disciplinary Code. A Regional Director in turn clarified that a draft document (prepared by an outside consultant) had been received, but was generic, did not distinguish among types of staff (e.g. civil servants versus contract workers) and was not specifically crafted to the operations of the regional authorities.

Table 4.1 Management Decentralization in Jamaica: Evaluation Matrix

Perceived Benefit	Observations
1. Staff	
<ul style="list-style-type: none"> • Better Working Conditions • Improved Staff Morale • Greater Stability (fewer resignations) • More say in management of service delivery 	<p>Too early to assess any of the “Perceived benefits of decentralization. These items need to be reduced to measurable indicators or processes and incorporated into Service Agreements with Regional Health Authorities (RHAs).</p> <p>RHAs should, in turn use these same measures to monitor progress of service delivery etc. at hospital and parish level.</p>
2. Community	
<ul style="list-style-type: none"> • Easier access to health care • User friendly environment • Faster, better service • More participation in decisions that affect their health 	
3. Desired Outcomes	
<ul style="list-style-type: none"> • Provide better & faster service • Contain costs by integrating service • Foster greater community participation • Strengthen health planning 	
Benchmark Tasks	
Legislation	
Pass necessary law[s] to give effect to new structures and arrangements	
Authority Structures	
Appoint RHAs	
Appoint HMCs	
Appoint PMCs	
Establish physical offices	
Management	
<ul style="list-style-type: none"> • Appoint Regional Directors • Appoint Regional Functional Officers (e.g. finance, information, and personnel) • Induction & Orientation of Regional Directors and functional officers 	
Management Systems/Resources	
<ul style="list-style-type: none"> • Transfer of assets • Transfer of staff • Install regional administrative procedures • Transfer & install regional personnel policies & procedures • Install Financial Instructions & Procedures • Planning (Services Agreements) • Performance Objectives for Regional Directors • Reconfigure the work of the Ministry 	

There are two distinct change processes stemming from decentralization. First is the establishment of the regional system. This includes the appointments of Regional Authorities, Regional Directors, Teams of Functional Officers for each region, and management arrangements at the Parish level. The second change process is the re-engineering of the work of the Ministry to be more focused on a planning, policy, regulatory and quality monitoring role.

The reform process is handled through a MOH Committee that includes the Regional Directors and MOH officials. Ideally, decentralization documentation and plans are to be discussed at this committee. Despite this notion, communications between the Ministry and Regional Directors seems to be deficient. We found a glaring disparity between the claims made by the Regional Directors and MOH officials suggesting that better communication mechanisms and forums are needed in order for decentralization to be successful. The starting point should be a clarification of the roles and functions of both parties and that this articulation should be done not only conceptually, but as concrete as possible to avoid further misunderstandings.

Some elements of the process went well. The Health Reform Unit conducted about three workshops on primary health care for the Regional Directors and their staff. These were useful and appreciated. Unfortunately, there were no comparable workshops for the many other topics faced by the Regional Directors. One Regional Director suggested that, given the varying professional backgrounds of the Regional Directors, a series of courses on health care management be offered to them.

The Decentralization Specialist noted some inconsistency between the Ministry maintaining that decentralization is its number one priority while at the same time it is “business as usual” for many departments of the Ministry. Although the Ministry headquarters has to be reformed as part of the decentralization initiative, the mechanism and person directly responsible management-wise for making this change happen is not clear. However, the MOH stated in its written comments to our initial draft report that

“...the redefinition of the roles of the Head Office has already been done and the devolution of duties to the Regional Authorities has commenced. Coopers and Lybrand have been selected as the consultants for leading the Change Management Process. Funding for this activity has been approved by the Inter-American Development Bank. The Health Reform Unit is also in the final stages of developing an Annual Service Agreement that spells out the expectations in terms of indices and standards. The next step is the signing of the contract so that the process will begin in October [1998]. There is also a Quality Assurance program.... These are two of the activities which we expect to assist us in moving the process forward.”

Moreover, in its response to our draft report, the MOH noted that specifics had been defined on four key areas of the decentralization project: restructuring of the Ministry of Health, decentralization of service delivery and management, health services, and quality assurance.

The Regional Directors felt frustrated by a lack of consultation about changes that might affect them, an absence of information, and an absence of documents. In summary, our review showed that given the capabilities and skills of those in key positions, the management of the change

process had not been done as well as it could have been. The team’s observations are summarized in Table 4.2:

- A poor relationship seems to have developed between the four regions and the MOH. This seems to revolve around a misunderstanding of the spirit and objectives of the decentralization project. The Regional Directors are interpreting the decentralization initiative as a reluctant shift in power from the Head Office to the four regions. If problems arise, the Regional Directors start to suspect ulterior motives.
- The induction of Regional Directors into the system has been inadequate and they have not been sufficiently prepared and supported for the considerable change management and strategic role they are expected to perform. At a basic level, Regional Directors had to sort out and acquire offices for themselves and their staff. There are salary inequities between the one Regional Director who has a physician background and the other three with non-medical training. There is also an imbalance of workload among the Regional Directors in terms of number of hospitals and bed size within each jurisdiction, scope of responsibilities, and complexity of duties. These have all contributed towards a souring working relationship between the Ministry and Regional Directors. Despite all of this, the Regional Directors seem to be a unified group who creatively try to work through the system and go beyond the noted constraints.
- The time line and arrangements for the transfer of critical areas of responsibility (staff secondments, personnel management and assets registers) have not been specified. In response to this observation, an MOH official stated that “ with respect to the time lines, there had to be great flexibility in the management of this [change] process, as it is part of a bigger Administrative Reform being undertaken in the entire Public Service. Time lines have been established for some activities and these have been shared and adjusted where necessary.”

Table 4.2. The Reform Process: Observations
1. Poor relationship developing between Regions and the MOH.
2. The induction of Regional Directors into the system and staff development/training for their role has been inadequate.
3. The time line and arrangements for the transfer of critical areas of responsibility [staff secondments, personnel management and payroll] have not been specified

4.4 Suggested Course of Action

The evaluation team suggests the following actions for the Ministry of Health, summarized in Table 4.3:

1. It would be useful for the Ministry Head Office to designate a single person with sufficient executive and management authority to manage the change process within the Ministry. This includes pushing through the devolution of duties to Regional Authorities and redefining the role of the Ministry. It is difficult for an official with substantial operational responsibilities, such as the Permanent Secretary, to take on this additional responsibility at the same time.
2. The evaluators commend the Ministry’s efforts in developing systems of planning, workload and quality monitoring. We recommend that Head Office share the drafts and seek the active

collaboration of the Regional Directors in this process. This change in approach, we feel, will help ensure that the resulting policies can be effectively implemented.

Specific to the Regional Health Authorities, the evaluators offer the following recommendations:

1. Regional Directors need to become familiar with current procedures and policies prepared by the MOH. In short, the Regional Directors need to have an updated, complete package of policies and procedures. More importantly, the Regional Directors need to be active (and not passive) reviewers and actors in MOH decentralization efforts. The approach should not be “top-down” where the Regional Directors are just implementers, but they should be treated as critical thinkers and professionals who can help shape and effectuate the change process.
2. In terms of training, the Regional Directors need specific training concerning health management and health care financing. Both short courses on the island, as well as overseas training would be useful. For example, an eight-week course at Harvard University entitled “Managing Health Programs in Developing Countries” had proved extremely useful to the CEO of May Pen Hospital. If finances allowed only one Regional Director to attend this course, he or she could bring back the information to peers. Further, the Regional Directors should attend a high level, hands-on change management course so that there is a uniform understanding of their roles in relation to MOH officers so that they can function more effectively at building up the regional system.
3. In an incremental fashion, Regional Directors should be given full responsibility and authority for health care reform activities in their region. In a “bottom-up” manner, the national program of reform should be built up from regional programs of action. Activities, timetables, and budget for reform activities should be included as part of the Annual Service Agreement with MOH and monitored as part of the process.
4. Staff and other responsibilities should be transferred to the four Regions according to an agreed upon and publicized timetable.
5. There should be a compensation review of salaries of the four Regional Directors, taking account scope of responsibilities and number of hospitals/total beds within a particular regional jurisdiction.

Table 4.3. The Reform Process: Suggestions
1. CEO for the Ministry
2. Regional Directors and Regional Technical Officers to be made responsible for reform activities in the four jurisdictions.
3. Change of terminology- “A Quality Service”?
4. Greater support for Regional Directors:
<ul style="list-style-type: none"> • Induction process • Equitable salary and authority/responsibility review
5. Mandatory change management training
6. Transfer of staff, personnel matters, and payroll

In closing, the evaluators were gratified by the statement in the MOH’s final comments that “the report contains several sound and practical recommendations that will be followed up with a view to implementation as soon as feasible.” The evaluators hope not to belabor any possible

past misunderstandings, but to further the collaborative process that all involved are seeking to implement.

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APPENDIX A. PERSONS INTERVIEWED FOR EVALUATION OF THE HSIP

<p>Savanna la mar Hospital (955-2159t,955-3949f) Verlie James Chief Executive Officer J. Barton-Campbell Dietitian Verna Stewart Matron Chris Morris Manager, Dual Security Petra McNab Manager, Agroway Ltd.</p>	<p>Spanish Town Hospital (984-2984,984-3031-3) Jean Allen Chief Executive Officer (Actg.) Beverley Hanson Contract Monitoring Officer Judith Craig Matron</p>
<p>Mandeville Hospital (962-1887, 962-3370) Dr. Peter Wellington Senior Medical Officer Paulette Elliott Chief Executive Officer (Actg.) Beverita Beckford Matron Mrs. Juanita Morgan Administrator Millicent Lewis Accountant Myra Davey-Morgan Departmental Sister (Actg.)</p>	<p>Kingston Public Hospital (922-0210 to 9) Carlene Nugent Chief Executive Officer Gloria Robinson Patient Services Officer C. Gregory Director Finance Winston Broadbell Administrator KPH Brenda Clayton Administrator VJH Leaford Rodney Security/Safety Manager Valrie Bogle Deputy Matron Beverley Lee Regional Dietitian Eugene Humphrey Infection Control Officer Winston Harvey Contract Monitoring Officer</p>
<p>May Pen Hospital (986-6307) Dr Winston Dawes Senior Medical Officer Lorna Salmon-Baker Chief Executive Officer Pearlinda Anderson Matron</p>	<p>Cornwall Regional Hospital (952-5100) Dr Dixon Senior Medical Officer Stephanie Reid Chief Executive Officer Ancylin Morgan Matron Garth Grant Chief Accountant Una Reid Housekeeping Sup</p>
<p>Bustamante Hospital for Children (929-2631) Major Conrad Atkinson, Chief Executive Officer Sister Bernard Nurse Mr. Gordon, Divestment Management Contract Services (DIMACS)</p>	<p>St. Ann's Bay Hospital (972-2272) Dr. Horace Betton, Senior Medical Officer Mrs. Willis, Retired Matron Miss A. Davidson, Fee Collections</p>
<p>Regional Directors Mrs. Paola Arscott South Eastern (754-3442/3) Miss Fay Petgrave, Southern (962-9491) Mr. Owen Belvett, North Eastern (975-5782) Dr. Shelia Campbell-Forrester, Western (952-2963)</p>	<p>Ministry of Health (926-6576) Dr. Marjorie Holding-Cobham, Director Health Reform Unit Mr. Stanley Lalta, Econ., Health Reform Unit Mr. George Briggs, Permanent Secretary Dr. Peter Figueroa, Chief Medical Officer</p>
<p>Health Sector Initiatives Program (967-1100t, 967-1303f) Miss Hyacinth Allen, Director Mr. Barad Singh, Health Financing Specialist Mr. Donald Prince, Divestment Specialist</p>	<p>USAID, Kingston (926-3645) Ms. Bernita Forte, Acting Mission Director Mr. Daniel Gordon, Office of General Devel. Miss. Grace-Ann Grey Miss Bridget Fong-Yee</p>

APPENDIX B. SUPPLEMENTAL DATA FOR ANALYSIS OF COST RECOVERY

Table B.1. Financing of an average inpatient admission, 1997-98 (J\$)

	Mande- ville	St. Ann's Bay	May Pen	Sav- la Mar	Spanish Town	Corn- wall	AVER- AGE
Fee collections	722	977	633	1,144	1,334	1,156	778
Bad debt	1,429	834	723	1,423	2,824	2,224	995
Total billed	2,151	1,812	1,356	2,567	4,158	3,380	1,773
Planned subsidy	8,100	9,019	9,556	9,073	8,655	16,187	11,510
Total cost	10,251	10,830	10,912	11,640	12,813	19,567	13,283
Fee collections	7%	9%	6%	10%	10%	6%	6%
Bad debt	14%	8%	7%	12%	22%	11%	7%
Total billed	21%	17%	12%	22%	32%	17%	13%
Planned subsidy	79%	83%	88%	78%	68%	83%	87%
Total cost	100%	100%	100%	100%	100%	100%	100%

Financing of an average ambulatory visit, 1997-98 (J\$)

	Mande- ville	St. Ann's Bay	May Pen	Sav- la Mar	Spanish Town	Corn- wall	AVER- AGE
Fee collections	164	204	164	164	164	164	164
Bad debt	41	51	41	41	41	41	41
Total billed	205	255	205	205	205	205	205
Planned subsidy	420	346	460	401	377	525	367
Total cost	625	602	665	606	582	730	573
Fee collections	26%	34%	25%	27%	28%	23%	29%
Bad debt	7%	8%	6%	7%	7%	6%	7%
Total billed	33%	42%	31%	34%	35%	28%	36%
Planned subsidy	67%	58%	69%	66%	65%	72%	64%
Total cost	100%	100%	100%	100%	100%	100%	100%

Table B.3 Detailed data on cost recovery in study hospitals

	Potential MOH	Current MOH	Spanish Town	Savanna la Mar	Corn- wall	St. Ann's Bay	Mande- ville	May Pen	Noel H. Lucea
Beds			285			150			
Occupancy (%)						90.4%			
Beds (acute) '97	3777	3777	258	157	322	139.00	167	150	52
Discharges '95	128,332	128,332	14,887	7,375	12,133	7,715	10,776	4,479	2,111
Patient Days '97			99798			45,846			
Admissions '97	154,015	154,015	16,966	8,102	16,219	9,009	11,612	4,550	1,697
Average length of stay, 97 (days)	5.8	5.8	5.5	4.8	6.7	4.5	4.1	4.1	6.4
Est. Patient Days '97	893,287	893,287	93,313	38,890	108,667	40,541	47,609	18,655	10,861
Casualty visits	599,117	599,117	49,029	29,696	72,765	45,607	45,500	28,938	15,666
Outpatient specialty	453,758	453,758	30,036	11,597	70,818	8,524	32,173	1,949	692
Ambulatory visits '97	1,052,875	1,052,875	79,065	41,293	143,583	54,131	77,673	30,887	16,358
Cost recovery actual (J\$ million)	248.5	248.5	35.7	15.55	45.9	18.92	21.81	8.41	2.32
Average inpatient invoice:									
Amount billed (sample, J\$)	2,571	2,571	4158	2567	3380	1,812	2151.1	1356	
Collected during stay (sample, J\$)				1129		267	653	465	
Collected after stay (sample, J\$)				777		222	69	168	
Total collected (sample, J\$)	2,571	1,040	1,334	1906	1156	489	722	633	
Adjustment factor	80%	69%	100%	60%	100%	200%	100%	100%	
Adjusted collected (sample, J\$)	2,057	718	1,334	1,144	1,156	977	722	633	
% collected during stay				44%		15%	30%	34%	
% collected after stay				30%		12%	3%	12%	
Adj. % collected total (sample)			32%	45%	34%	54%	34%	47%	33%
Exemption rate						5%			
Number of invoices						8,559			
Potential inpt. revenue (J\$million)						15.51			
Expenditure 96-97	2,478.60	2,478.60	269.00	116.50	371.58	119.30	141.40	57.50	26.60
Revised budget 97-98 (J\$million)	2,942.90	2,942.90	292.70	132.60	469.10	144.60	186.20	78.00	30.80
90% rev. budget 97-98 (J\$million)	2,648.61	2,648.61	263.43	119.34	422.19	130.14	167.58	70.20	27.72
Cost recovery actual (97-8)(%)	9.4%	9.4%	13.6%	13.0%	10.9%	14.5%	13.0%	12.0%	8.4%
Ambulatory day equivalents	263,219	263,219	19,766	10,323	35,896	13,533	19,418	7,722	4,090
Patient days	893,287	893,287	93,313	38,890	108,667	40,541	47,609	18,655	10,861
Patient day equivalents	1,156,506	1,156,506	113,079	49,213	144,563	54,073	67,027	26,377	14,950
Ambulatory share, %	23%	23%	17%	21%	25%	25%	29%	29%	27%
Inpatient share, %	77%	77%	83%	79%	75%	75%	71%	71%	73%
Est. inpatient expend. J\$million	2,045.79	2,045.79	217.38	94.31	317.36	97.57	119.03	49.65	20.14
Expenditure per admission (J\$)	13,283	13,283	12,813	11,640	19,567	10,830	10,251	10,912	11,867
Inp. fee as % of inp. expenditure	19.4%	19.4%	32.5%	22.1%	17.3%	16.7%	21.0%	12.4%	0.0%
Inpt. collect. % of expend. (sampl	15.5%	5.4%	10.4%	9.8%	5.9%	9.0%	7.0%	5.8%	0.0%
Outpatient expenditure (J\$mil)	602.82	602.82	46.05	25.03	104.83	32.57	48.55	20.55	7.58
Cost/visit (J\$)	573	573	582	606	730	602	625	665	464
Revenue/visit (J\$)	164	164	164	164	164	204	164	164	164
Est. ambulatory revenue (J\$mil)	138.38	138.38	13	7	24	9	13	5	3
Amb. revenue/amb. Budget (%)	23%	23%	28%	27%	23%	27%	26%	25%	35%
Est. inpatient revenue (J\$mil)	317	111	23	9	19	9	8	3	-
Est. total revenue (J\$ mil)	455	249	36	16	42	18	21	8	3
Est. total revenue/total costs	17.2%	9.4%	13.5%	13.4%	10.0%	13.6%	12.6%	11.3%	9.7%
Act. total revenue/total costs	9.4%	9.4%	13.6%	13.0%	10.9%	14.5%	13.0%	12.0%	8.4%
Cost recovery:									
Inpatient	15%	5%	10%	10%	6%	9%	7%	6%	0%
Ambulatory	23%	23%	28%	27%	23%	27%	26%	25%	35%
Total	17%	9%	14%	13%	11%	15%	13%	12%	8%
Inpatient share of hospital total:									
Expenditures	77%	77%	83%	79%	75%	75%	71%	71%	73%
Revenue	70%	44%	63%	60%	41%	47%	38%	34%	0%

APPENDIX C. WORKPLAN FOR EVALUATION OF THE HSIP

Revised August 19, 1998

Dates	D. Shepard, Team Leader	A. McNaught, Decentralization Specialist	Y. Anthony, Health Finance Specialist	K. Davis, Divestment Specialist
Sun., 9 Aug.	Am: Arrive in Kingston, pm: confer with team		am: Arrive in Kingston, pm: confer with team	Am: Greet team pm: confer with team
Mon., 10 Aug.	8 Am: Entry briefing at USAID, Kingston; 9 am: Dr Figeroa and MOH staff 10 am: Confer with HSIP secretariat; Pm: Spanish Town Hospital		8 Am: Entry briefing at USAID, Kingston; 9 am: Dr Figeroa and MOH staff 10 am: Confer with HSIP secretariat; Pm: Spanish Town Hospital	8 Am: Entry briefing at USAID, Kingston; 9 am: Dr Figeroa and MOH staff 10 am: Confer with HSIP secretariat; Pm: Spanish Town Hospital
Tue., 11 Aug.	5 Am: Drive from Kingston to Savanna- la-mar; 10 Am Savanna-la- mar Hospital; 4 Pm. Noel Holmes Hospital; Overnight in Montego Bay	6 pm: Arrive in Montego Bay, Pm: confer with team	5 Am: Drive from Kingston to Savanna- la-mar; 10 Am Savanna-la- mar Hospital; 4 Pm. Noel Holmes Hospital; Overnight in Montego Bay	5 Am: Drive from Kingston to Savanna- la-mar; 10 Am Savanna-la- mar Hospital; 4 Pm. Noel Holmes Hospital; Overnight in Montego Bay
Wed., 12 Aug.	8:30 Am: Cornwall Regional Hospital (cleaning/ portering); Overnight in Montego Bay	9 Am: Western Regional Office (Montego Bay), All 4 regional directors; Overnight in Montego Bay	8:30 Am: Cornwall Regional Hospital (cleaning/ portering); Overnight in Montego Bay	8:30 Am: Cornwall Regional Hospital (cleaning/ portering); Overnight in Montego Bay
Thu., 13 Aug.	Am, pm: St. Ann's Bay Hospital; Pm: Drive from St. Ann's Bay to Kingston	Am: Return to Kingston, 11 am Headquarters: Human Resources Management and Admin., and Health Reform Unit; Pm: South East Regional Office (Kingston)	Am, pm: St. Ann's Bay Hospital; Pm: Drive from St. Ann's Bay to Kingston	Am: Return to Kingston; Am, pm: Victoria Jubilee Hospital (cleaning/ portering, security, dietary)
Fri., 14 Aug.	8Am: Interim briefing with OGD, OPPD; 3 Pm: Bustamante Hospital for Children (cleaning/ portering, security)	8Am: Interim briefing with OGD, OPPD; Pm: Write up site visits, confer with team, prepare briefing	8Am: Interim briefing with OGD, OPPD Pm: Depart Kingston	8 Am: Interim briefing with OGD, OPPD; Pm: Write up site visits, confer with team, prepare briefing

Dates	D. Shepard, Team Leader	A. McNaught, Decentralization Specialist	Y. Anthony, Health Finance Specialist	K. Davis, Divestment Specialist
Sat., 15 Aug.	Am, pm: Write up site visits, prepare briefing			Am, pm: Write up site visits, prepare briefing
Sun., 16				
Mon., 17 Aug.	9 Am: Mandeville Hospital 2 Pm: May Pen Hospital	11 am: Southern Regional Office staff (from Mandeville) at MOH, Kingston; pm: officials in health reform unit		9 Am: Mandeville Hospital (cleaning/portering, security); 2 Pm: May Pen Hospital (cleaning/portering, dietary, security)
Tue., 18 Aug.	10 Am: Final debriefing with USAID and GOJ; pm: Confer with team; prepare draft report;	10 am: Final debriefing with USAID and GOJ pm: Confer with team; prepare draft report;		10 am: Final debriefing with USAID and GOJ; pm: Confer with team; prepare draft report;
Wed. 19 Aug.	8:30 Am: Final briefing for MOH staff; Pm: Depart Kingston	8:30 Am: Final briefing for MOH staff		8:30 Am: Final briefing for MOH staff; Pm: Prepare draft report
Thu. 20 Aug.	Prepare draft report			Am: Bustamante Hospital for Children; telephone contacts with hospitals
Fri. Aug 21 Tues. Sept 8	Prepare draft report		Prepare draft report	
Mon. Sept. 7	Submit draft report			
Mon.. 14 Sept	Receive comments from MOH; Prepare final report			
Mon. Sept. 21.	Final report due			

APPENDIX D. HSIP EVALUATION, STATEMENT OF WORK

I. ACTIVITY TO BE EVALUATED:

Project Name:	Health Sector Initiatives Project (HSIP)
Project Number:	532-0152
Authorized LOP Funding:	US\$5 million
Authorized Date:	July 7, 1989
Project Assistance Completion Date:	September 30, 1998

II. PURPOSE OF THE EVALUATION

The purpose of the evaluation is to: (1) assess the extent to which health reform activities under the Health Sector Initiatives Project (HSIP) have achieved their objectives, (2) provide recommendations regarding what is needed to promote the sustainability of these activities, once USAID assistance ends, and (3) provide accomplishments and lessons learned in the areas of cost recovery, decentralization and divestment to the Mission, AID/W, MOH and others regarding health policy reform.

III. BACKGROUND

The MOH and HISP project staff were consulted regarding issues and concerns about the sustainability of project reforms that have been achieved, as USAID assistance ends. The emphasis on this evaluation is to provide information that will benefit the MOH as it continues its work in health reform. As noted above, the Inter-American Development Bank (IDB) is supporting health reform, so it is anticipated that evaluation findings and recommendations will be useful to the IDB in its continuing work.

Continued collaboration between USAID and IDB during the last months of project implementation will ensure a smooth transition. The project goal is to improve the health status of Jamaicans by working simultaneously with the public and private health sectors. The public sector component, implemented by the GOJ, was to analyze and formulate policy options to finance and more effectively manage the delivery of health care. The private sector component of the project, implemented by the Private Sector Organization of Jamaica (PSOJ), managed private sector activities including exploration of methods of privatizing health care delivery, promotion/development of primary health insurance schemes, and administration of a small grant program, targeted to the private sector.

The Pan American Health Organization (PAHO) managed all the long-term local technical assistance and the social marketing component of the project. Short-term US technical assistance in health care policy and financing was provided by the University Research Corporation (URC), with hospital management development training being provided by the Association of University Programs in Health Administration (AUPHA).

The public sector component of the project originally included two categories of activities, including financing and management. Specific activities under the financing category included: a) increasing cost recovery through user fee reforms; b) sustainable financing, including the promotion of private health insurance coverage for those capable of paying, cost containment, and the development of financing and management systems for the indigent; and c) social marketing.

Specific activities under the management category included: a) support and possible replication of the Primary Health Care Operations Research (PRICOR) test model; b) identification of priority management problems and the strengthening of secondary care administration in two pilot hospitals; c) strengthening of headquarters; d) drug management, e) alternative management of public facilities including the contracting out of hospital support services (divestment) and support of the MOH's plan to decentralize PHC areas and to develop fully integrated primary and secondary care decentralized regions (decentralization).

The private sector component of the Project included a series of private sector health studies/demonstration activities and twenty private sub-grants to promote increased private sector involvement in health care. Based upon project supported research, it was learned that in the Kingston Metropolitan Region (KMR), 82% of persons without health insurance would take out health insurance if it were made available at an affordable cost. Likewise, 61% of persons outside KMR stated they would do the same. Due to the identified demand for health insurance, this project component emphasized support of private sector health insurance, including the concept of a Pre-Paid Health Plan. The project supported studies and technical assistance to establish pre-paid health plans in two pilot hospitals, however, the Ministry of Health, USAID and the PSOJ never agreed to the basic premise of such a plan, therefore it was not implemented. However, aspects of the Pre-Paid Plan are being implemented at Cornwall Hospital, independent of USAID support.

In 1992, a project management review was carried out due to the slow implementation of the project. The review concluded that progress had been made in cost recovery, contracting out of hospital services, and the establishment of the HSIP Secretariat, but stated that the project had lost momentum. Major recommendations included the need for a Decentralization Action Plan, training for senior personnel and finance officers, the hiring of eight hospital CEO's, and the preparation of a strategic workplan. The resultant Strategic Plan modified the original project design and redefined the project purpose to increase the efficiency and decentralization of the public sector health care system and to increase the proportion of health care service delivery and financing provided by the private sector.

The 1994 interim evaluation team viewed hospital cost recovery as the most successful project component, and saw cost recovery as being critical for the project to have lasting value for Jamaicans. The evaluation, therefore, recommended that all project components focus on enhancing cost-recovery and resource generation during the final two years of project implementation.

The Inter-American Development Bank (IDB) provided a health sector reform loan and grant to the GOJ that complements USAID assistance in health reform. The IDB recently initiated a follow-on Health Reform Loan. USAID has coordinated with the IDB during the last months of project implementation to promote a smooth transition and to promote IDB support of activities that require additional financial and technical resources.

IV. EVALUATION STATEMENT OF WORK

The evaluation will focus on decentralization, as well as cost recovery and divestment which are seen as key components in health reform and financing. The multidisciplinary three person team consisting of experts in evaluation, finance and health policy/decentralization will also focus on decentralization and the divestment aspects of the project.

The evaluation team will consider and specifically address the following questions and issues:

Health Finance Specialist - 9 days in country

Cost Recovery

1. What strategies are being used to recover fees and what can be done to further increase recovery rates? The present rate of recovery being achieved is approximately 10% of total hospital expenditure, however the project target was 20%. Comparison of the rates of recovery between CEO managed hospitals and non-CEO managed hospitals may provide insight into the effectiveness of cost recovery, based on hospital management style.

Issues that will be reviewed/addressed in regard to this include how fee schedules are established, changes in fees as hospital costs increase, and uniformity of fees in all hospitals. Information regarding fees collected by each hospital will be available to the team, prior to initiation of the evaluation.

2. The interim evaluation identified the need for the development of hospital guidelines regarding the use of fees, therefore, guidelines for use of hospital fees collected require review.

3. Assess the administrative systems that are in place for hospital fees collection. This will include review of the forms that are used, assessment of the procedural manuals that have been developed for hospital use, the assessment of affordability (interviews and completion of assessment forms), billing and accounting system.

4. The evaluation will assess the extent to which hospital services have improved and client satisfaction has increased, as a result of the hospital cost recovery system. Are patients more willing to pay for services following sensitization of patients and hospital staff to the need for hospital fees collection and improved services?

5. What is the overall impact of hospital fees collection on health care financing?

6. The evaluation will verify information on how many or what share of public hospitals collect fees? And whether CEO's consider that cost recovery provides them with a greater discretion in resource allocation.

7. Along with a report, the evaluation will provide graphs/tables to demonstrate evaluation findings. The graphs/tables will be submitted in Lotus 1-2-3 Release 4.

Team Leader/Health Policy Specialist - 15 days in country

Decentralization

Legislation was passed by Parliament on February 25, 1997 and promulgated by the Minister of Health on October 1, 1997, to provide for the creation of four Regional Health Authorities to manage the island's health services and facilities. The Minister of Health stated that "the decentralization of the management of health services is designed to facilitate the provision of cost-effective...integrated health care of an acceptable standard to the public".

While awaiting the passage of legislation, activities have been initiated by the project, including the identification of four locations to serve as Regional Offices, establishment of four Regional Steering Committees to facilitate a smooth transition as decentralization occurs, establishment of administrative mechanisms to support the restructuring and decentralization process (studies on manpower needs, the identification of new staff requirements, initial recruitment of regional staff,

and development of management, computer and personnel training for new regional staff), and reorientation of selected staff to the concept of decentralization.

Issues to be addressed under the decentralization component include:

1. A review of the status of activities initiated by the project in anticipation of passage of legislation (passed February 25, 1997) and identification of required actions to fully achieve decentralization in the four regions. This will include the restructured and strengthened management of headquarters to support decentralization, especially reoriented toward regional offices; decentralized management structures/systems (accounting/budgeting, personnel management, MIS/HIS) in place in the regions supporting primary and secondary care; and improved management systems and managers (CEOs) in place in project hospitals. Per the interim evaluation's recommendation to transfer major hospitals to a semi-autonomous legal status, thereby permitting government boards and managers to be at risk for the success of their institutions, the extent to which this was accomplished should be reviewed.
2. Assess the organizational relationship between Head Office and the four regional offices.
3. At what level is the Ministry of Health in the decentralization process and what has been the lessons learned in getting to this stage? What are the following stages of decentralization and can this be sustained?

Local Consultant (Divestment) - 10 days

Divestment

1. The evaluation will briefly review the status of divested hospital support services, their quality and cost-effectiveness in the following hospitals:

Spanish Town -	Cleaning/portering, dietary, laundry, security
Mandeville -	Cleaning/portering, security
Bustamante Hospital -	Cleaning/portering, security
MayPen	Cleaning/portering, dietary, security
Savanna-la-Mar	Dietary, security
KPH/VHJ/Mona Rehab	Cleaning/portering, dietary, security
CRH	Cleaning/portering

2. The evaluation is required to review the management of the divested services.
3. The team is required to determine the reduction in the level of direct employment resulting from the divestment exercise.
4. The team is required to assess the impact of divestment in the following areas: cost, quality of service, availability, reliability and sustainability of service, development of entrepreneurial skills in the provision of health support services.

(a) Suggested Methodology

The evaluation team members will use both primary and secondary sources of data on which to base their findings. Primary information will be collected through interviews and/or surveys of key project, hospital

and private sector staff, health care beneficiaries (in-patient and out-patient), and relevant representatives of USAID, Ministry of Health, hospital administration, HSIP Secretariat, etc.

The Health Finance Specialist member of the team will also review secondary data including cost recovery data collected by the hospitals, forms and guidelines used in determining fees liability, manuals and procedural guidelines, etc. Based on information collected, provide graphs/tables to demonstrate findings.

The team will have access to all records maintained on the project by USAID, the Ministry of Health, the HSIP Secretariat and PSOJ.

Based on the team member's responsibility they will visit a variety of public hospitals throughout Jamaica, depending upon their role in the evaluation. For example, the health finance person will visit a variety of hospitals based either on the type of hospital (class A, B or C), the management style, i.e., CEO versus non-CEO, or selected hospitals based on the rate of fees collected (two hospitals that have the highest and two that have the lowest rate of collection). The Team Leader/ Health Policy Specialist will visit all four regional offices as well as headquarters.

(b) Evaluation Team Composition

The evaluation will be conducted by a multidisciplinary three person team consisting of experts in evaluation and finance and health policy/decentralization. At least one of the team positions will be filled by a Jamaican national. Previous work experience in Jamaica or the Caribbean is preferable, as are experience and expertise drawn from work in other countries.

Team Leader/Health Policy Specialist

A senior evaluator with at least ten years experience in the implementation and evaluation of health sector reform projects, and significant experience in leading evaluation teams, is desired. The team leader should be an economist with a public health background. The leader should have a broad understanding of issues and constraints in the delivery of Jamaican health care, health policy and reform. In addition to being the team leader, he/she will be responsible for addressing evaluation issues specifically related to decentralization. The leader should be available for 15 days (6 day work weeks) in Jamaica and three (3) days total at the contractor's office, following the team's work in Jamaica for preparation and completion of the final report. The team leader will work along with the health finance specialist and the local consultant but have the ultimate responsibility for presenting a final report, acceptable to USAID and the Ministry of Health. The team leader will have good interpersonal skills and ability to work with mid and higher-level decision-makers and program personnel, including foreign donor and government representatives.

This person will have overall responsibility for the quality and completeness of the report and that he/she supervises and guides the other team members to ensure the quality and completeness of their contributions.

The team leader will address the decentralization component.

Health Finance Specialist

The health finance specialist should have a relevant graduate degree in health finance, extensive experience (5-7 years minimum) in the implementation and evaluation of health finance projects

with emphasis on sustaining progress achieved. The health finance specialist should possess a solid analytical and writing skills and demonstrate the ability to work with mid and higher level decision makers in government and foreign donor representatives. The specialist will work with the team leader in review of studies and reports and the preparation and completion of draft and final reports.

The health finance specialist should address the cost recovery component.

Local Consultant (Divestment)

The local consultant will have experience in implementation of the divestment of government services also the ability to assess requirements to sustain the divestment of hospital services and possess a solid analytical and writing skills. The local consultant should have a business management degree with a concentration in financial analysis and a background in public health. The local consultant will work with the team leader in reviewing studies and reports and the preparation and completion of draft and final reports.

The local consultant should address the divestment component.

(c) Reporting Requirements

On the first day of their work in Jamaica, the team will hold an entry briefing with the USAID Director, The Office of General Development Staff, the USAID Evaluation Officer and other members of USAID/Jamaica staff. The team will also meet with members of the HSIP Secretariat and the Ministry of Health. Within two days of the entry briefing, the team will submit a workplan to the USAID Office of General Development (OGD) office for approval. The team will hold an interim briefing with the Office of General Development (OGD) and the Office of Program & Project Development (OPPD) within 8 days of receipt of the workplan.

The team leader shall provide ten copies of the draft report including the cost recovery tables to USAID for distribution and review at least two days prior to the final debriefing for USAID and GOJ Ministry of Health officials. The team leader will be responsible for incorporating comments/ revisions as appropriate and submitting ten copies of the final revised evaluation report in WordPerfect 5.2, along with a diskette no later than 1 week after receipt of comments from USAID. He/she will also be responsible for completing the abstract and narrative sections of the USAID Project Evaluation Summary form which should accompany the final report.

The final report will include an Executive Summary, Identification Data Sheet, Table of Contents, Report Body and Appendices.

The Executive Summary will briefly state the development objectives, the purpose of the evaluation, methodology used. The emphasis will be on evaluation findings, conclusions, recommendations, Lessons Learned, and prospects for continuity of project components.

The body of the report will include discussion of: (1) the purpose and questions of the evaluation; (2) the economic, political and social context of the project; (3) team composition and evaluation methods; (4) findings of the study regarding the evaluation questions; (5) conclusions drawn from the findings; (6) recommendations based on the study findings and conclusions; these should be stated in actions to help to sustain project components once USAID assistance ends; and (7) Lessons Learned. The body of the report should be no more than 30 pages.

Appendices will include the evaluation Statement of Work, a list of documents consulted, individuals and agencies contacted and other documents relevant to this evaluation.

The cost recovery tables/graphs should be submitted in LOTUS 1-2-3 Release 4.

(d) Level of Effort

Team leader/health policy specialist - 12 work days
Health finance specialist – work 9 days
Local consultant – 10 work days
Decentralization specialist – 5 work days

(e) Relationships and Responsibilities

The contractors will report directly to the Director of the Office of General Development or his designee and will maintain close and frequent contact with the HSIP Project Consultant OGD, with weekly informal status reports to be provided to the relevant SO3 team members and the Office of Program and Project Development (OPPD).

(f) Logistical Support

The Ministry of Health will assist the contractor with arrangements for interviews and site visits. The contractor will be responsible for making all arrangements for international and in-country transportation, lodging and secretarial support (including photocopying). The contractor will also be responsible for providing its own computers and printers. The HSIP Secretariat will provide office space.