CaPRI
Caribbean Policy Research Institute

HEALTH ACCESS STUDY

Fee or Free?

A Survey of the No-user Fee Policy in Public Hospitals in Jamaica

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2013

This work was carried out with the aid of grants from the
International Development Research Centre, Ottawa, Canada,
the Gleaner Company Limited, Jamaica, and
the National Health Fund, Jamaica.

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Lead Researcher: Dr. Lloyd Waller

Contents

List of Tables

List of Figures

Executive Summary

As part of its commitment to universal access to health care, in 2008, the Government of Jamaica removed user fee for services at public hospitals except the University Hospital of the West Indies. This was a significant departure from a policy of user fee reintroduced in 1984.

The impact of the no-user fee policy on Jamaica's health care system has been largely anecdotal[1]. In light of this, CaPRI undertook a national survey over five weeks from April 15 to May 20, 2013 across all fourteen parishes in 14 public hospitals to garner the views of health workers, patients and the general public on the policy.

Free Health Care

The study revealed that majority of the doctors and nurses oppose free medication; and no-user fees. Doctors and nurses are of the view that "those who can pay should pay". Contrastingly, majority of patients are in support of free medication, no-user fees as well as the view that "those who can pay should pay". These views, when segmented across the different income groups revealed that of the three groups (low, middle, high), higher wage earners are less likely to support free medication; removal of user fees or be of the belief that "those who can pay should pay". Patients in support of the removal of user fees rationalized their stance on the grounds of affordability and accessibility, whereas those who oppose indicated that free health care is not sustainable and has had far reaching negative implications on the quality of service in Jamaica's health care system.

Responsibility

More than three quarters of the sampled nurses and doctors indicated that health care should be a shared responsibility of both the government and the individual. Patients on the other hand, are of the belief that health care is the responsibility of the government. Lower income earners were also of the belief that health care should be the responsibility of the government, whereas higher income earners believe that it should be a shared responsibility between the government and the individual.

Impact

According to doctors and nurses, abolition of user fees had its most far-reaching impact on pharmaceutical supplies, followed by staff, medical supplies, waiting time, space, service delivery and processing time. Majority of patients in fact observed that the abolition of user fees impacted waiting time. However, they noted that although they had to wait longer, this did not shorten their consultation time.

For a paper submitted to the Sessional Select Committee on Human Resources and Social Development by the Medical Association of Jamaica on September 25, 2011, see The impact of a no-user-fee policy on the quality of patient care/service delivery in Jamaica.

Introduction

In the 1980s a number of developing countries introduced user fees as a means of improving the quality of their health care systems in order to increase utilisation of services (Lagarde and Palmer, 2011). This policy was supported by the IMF and the World Bank (World Bank, 1987) in a move towards more pro-market reforms.

After 24 years of user fees in public hospitals, on 1 April 2008, the Government of Jamaica introduced a no-user fee policy applicable at all public health facilities across the island, except the University Hospital of the West Indies. The policy was part of the government's commitment to universal access[2] to health care at the primary-care level. In introducing the system, the Minister of Health noted that a significant barrier to access health care is the cost of health services. In this regard, abolishing fees at public hospitals would not only provide access to health care but would also avoid the catastrophe of what is called the 'medical poverty trap' phenomenon. Greater access to health care would certainly help Jamaican to achieve the Millennium Development Goals on maternal health and infant mortality.

In reporting to parliament in 2010[3] the Minister of Health noted that the abolition of user fees had resulted in more persons using the primary health care system with health centre visits increasing in the first year by 16.3 percent and 7.8 percent in the second year. Accident and Emergency visits however, declined marginally by 0.4 percent in the second year after a 14 percent increase in the first year of the implementation of the policy. The Minister also reported that the first two years of the no-user fee policy at public health facilities had realized a saving of $4.4 billion for users accessing selected services such as pharmaceuticals and surgeries.

After five years of the no-user fee policy, there have been concerns about the State's ability to adequately fund[4] quality care across the health care system. This comes against the background of changing financing models in the health sector since independence. The table below outlines the types of interventions made by government in the health sector since 1968.

Given the foregoing, CAPRI undertook a national survey to capture the perception of doctors, nurses and patients on the abolition of user fees at public hospitals.

Table 1: User fees in Jamaica

Type of GOJ Intervention	Time period/ Year
Revised Fees	1968
Removed	c.1975
Reintroduced	1984
Adjusted Upwards	1993
Adjusted Upwards	1999
Adjusted Upwards	2005
Removed for children under 18 years	May 2007 to March 2008
Abolished for all public patients	April 2008 to??

(Source: Universal Coverage in Jamaica by Dr. Michael Coombs, Chief Medical Officer, Jamaica)

2."Universal healthcare" or "universal coverage" refers to a scenario where everyone is covered for basic healthcare services, and no one is denied care as long as they are legal residents in the geography covered.

3. 2010/11 Sectoral Debate http://www.jis.gov.jm/news/106-health/25373-MinHealth-jamaicans-save-4-14-billion-through-no-user-fee-policy

4. PAHO/WHO Country Cooperation Strategy 2010-2015 highlights health care financing and sustainability of health services as a major challenge for Jamaica http://www.who.int/countryfocus/cooperation_strategy/jamaicaccs2010.pdf

Objectives

The main objective of the study was to investigate the effect of the no-user fee policy on health services in Jamaica and to explore the scope for returning to a fee paying system in the future.

Specific objectives:

- To assess the impact of user fees on the quality of health services and on the utilization of government health facilities;
- To collect views regarding the sustainability of the user fees program from health workers, patients and the general public; and
- To highlight the policy options available.

Methodology

The report is based on data collected over five (4) weeks from April 15 to May 20, 2013. Data were across all fourteen parishes in 14 public hospitals:

1. Black River Hospital
2. Savanna-la-mar Public General Hospital
3. Mandeville Hospital & Percy Junior Hospital
4. Port Antonio Hospital & Buff Bay Hospital
5. Annotto Bay Hospital & Port Maria Hospital
6. Spanish Town Hospital & Linstead Hospital
7. Bustamante Hospital for Children
8. Noel Holmes Hospital
9. Kingston Public Hospital
10. Princess Margaret Hospital
11. Cornwall Regional Hospital
12. Falmouth Hospital
13. St. Ann's Bay Hospital
14. May Pen Hospital & Lionel Town Hospital

Two different questionnaires (one for doctors and nurses and the other for patients) were administered to determine the effects of the no-user fee policy on human, financial and physical resources of the hospitals; to evaluate the impact of the no-user fees on waiting time at public hospitals; to assess the perceptions of regional administrators, doctors, nurses, pharmacists and patients on the payment of fees; and to identify the demographics of persons who access and use public hospitals.

Sampling Procedure

The quota sampling technique was most suitable in selecting a representative subset of the Population. Two different subsets (doctors and nurses as well as patients) were drafted to complete the study. Data were presented in the form of tables, charts and graphs and were analyzed using the Statistical Package for the Social Sciences (more commonly referred to as SPSS). Frequencies and crosstabs were used to provide descriptive and inferential information about the study. Also, qualitative data were analyzed using the constant comparative technique and visualized using the X-Mind software.

Key Findings

In this section of the report, the key findings are presented around themes of access, responsibility and impact.

The efects of no-user fees on the human, financial and physical resources of hospitals

Doctors and nurses were presented with seven possible implications of the no-user fee policy on the health care system. The analysis suggests that they are of the belief that the introduction of no-user fees had the greatest impact on pharmaceutical supplies, followed by staff; medical supplies; waiting time; space; service delivery and processing of patients.

Figure 1: Doctors and Nurses perception of the impact of the no-user fees on public hospitals

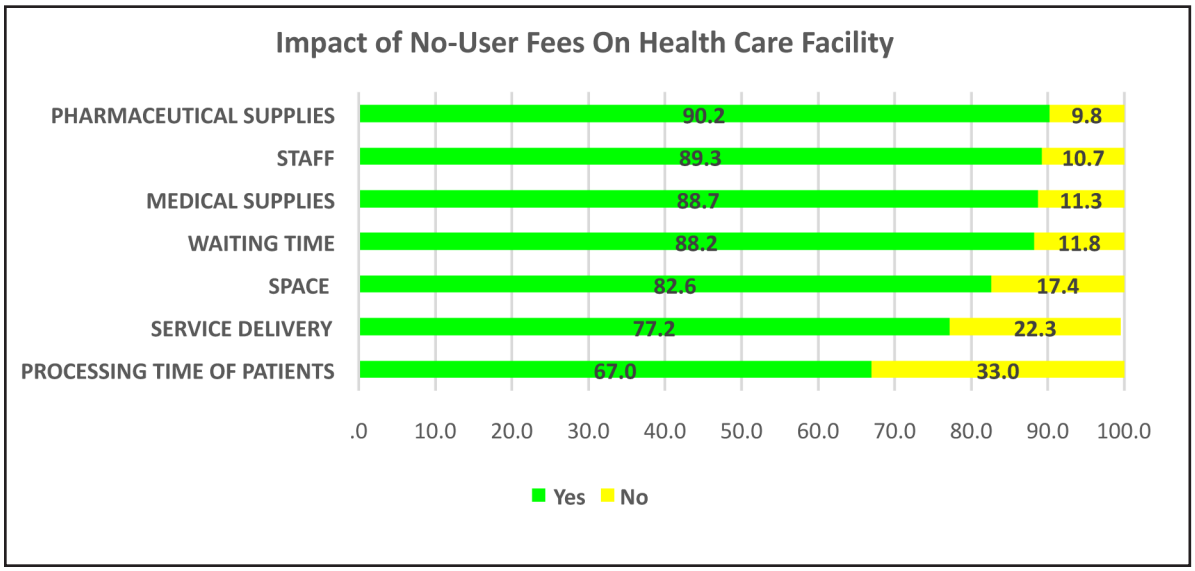


Figure 2: Effect on Pharmaceutical Supplies

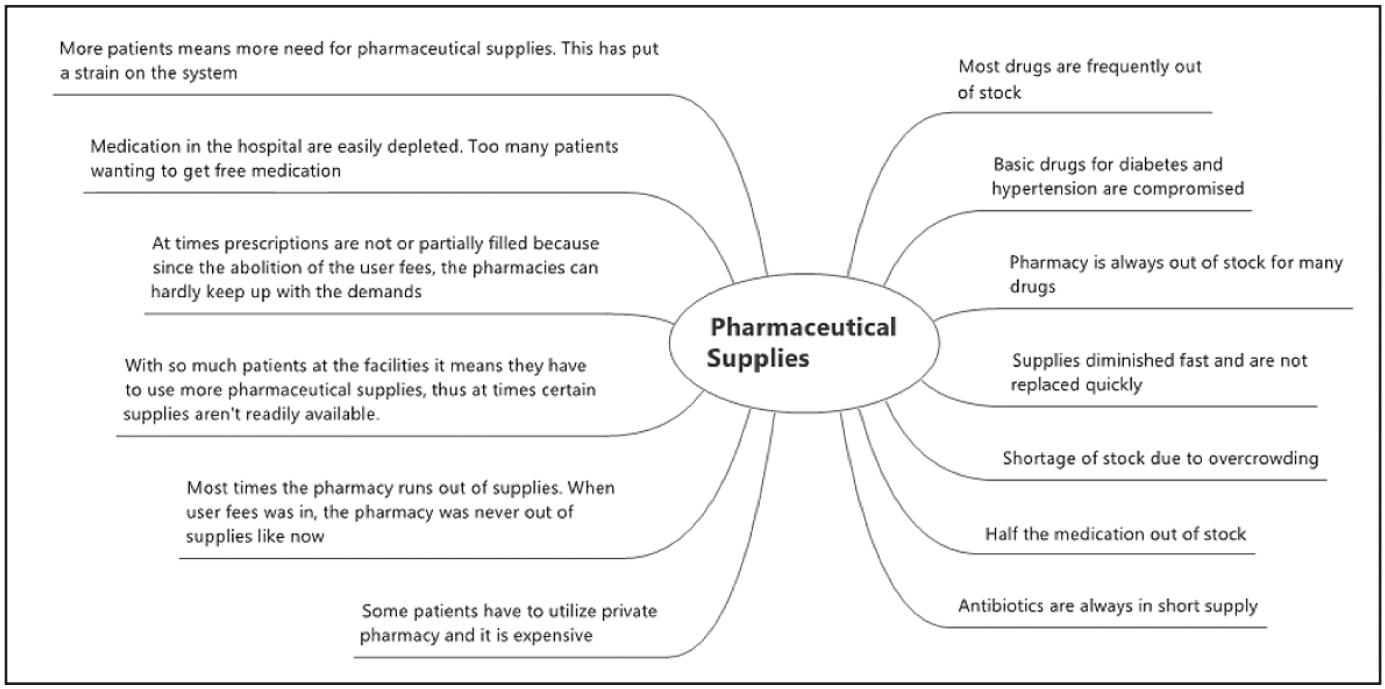


Figure 3: Effect on staff

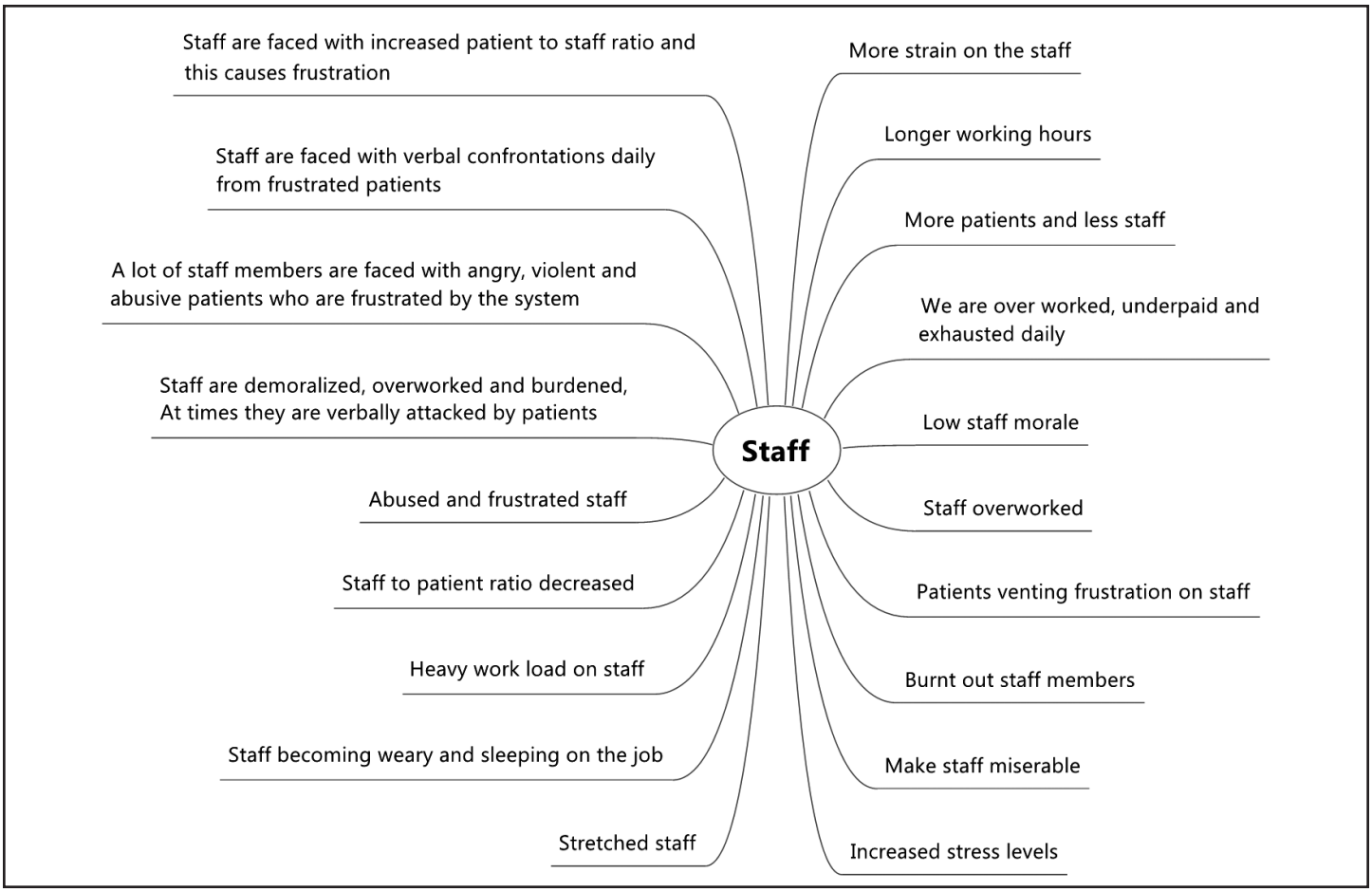


Figure 4: Effect on Medical Supplies

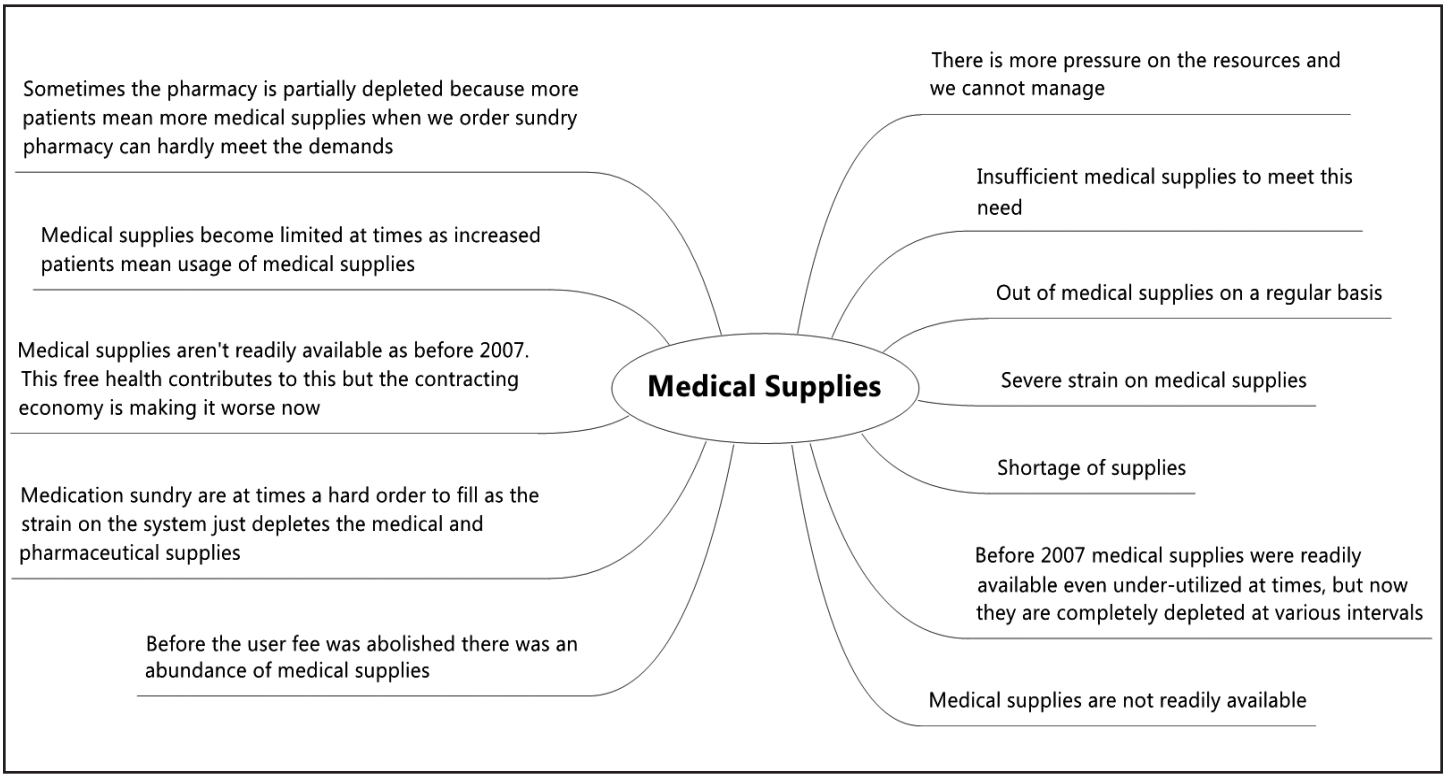


Figure 5: Effect on waiting time

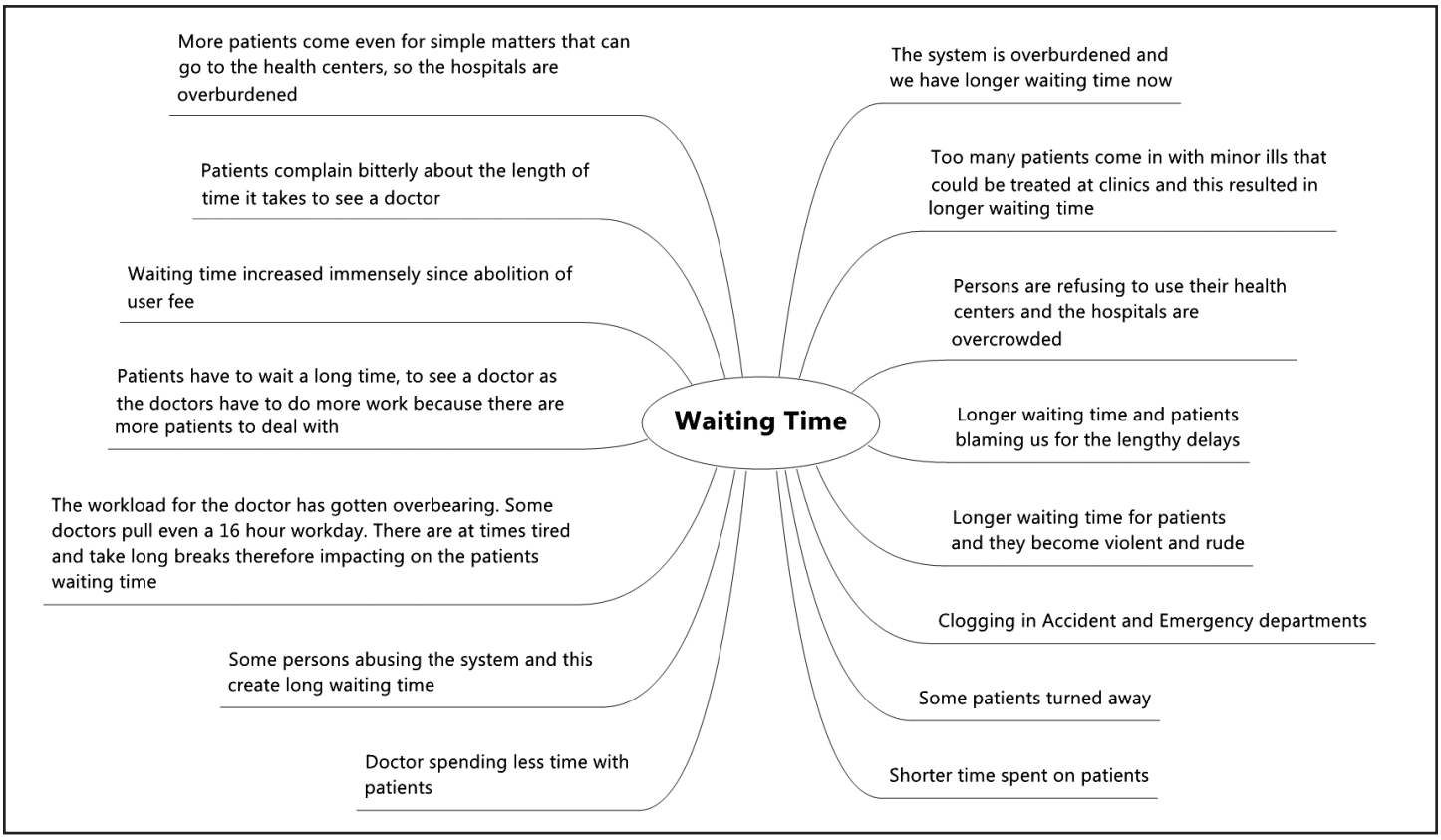


Figure 6: Effect on Space

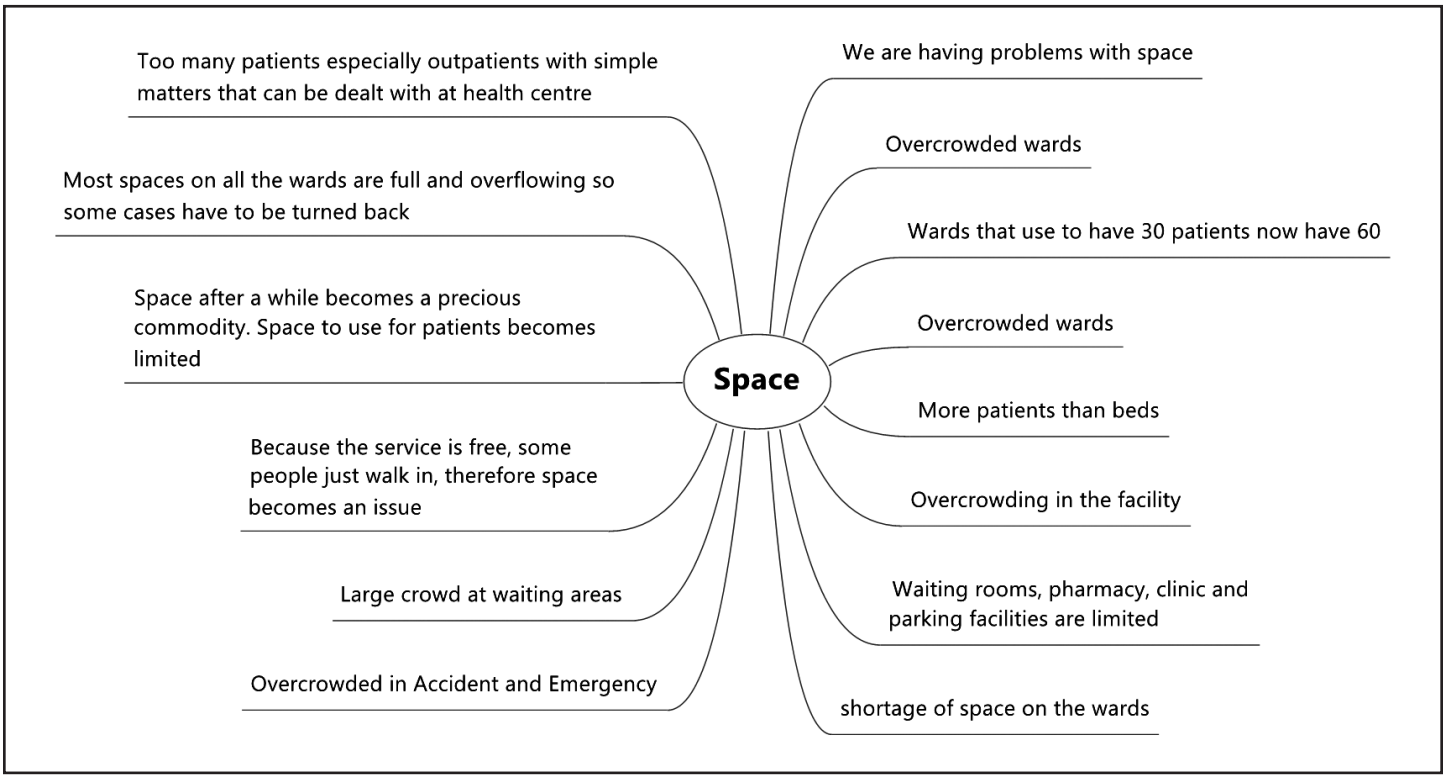


Figure 7: Effect on Service Delivery

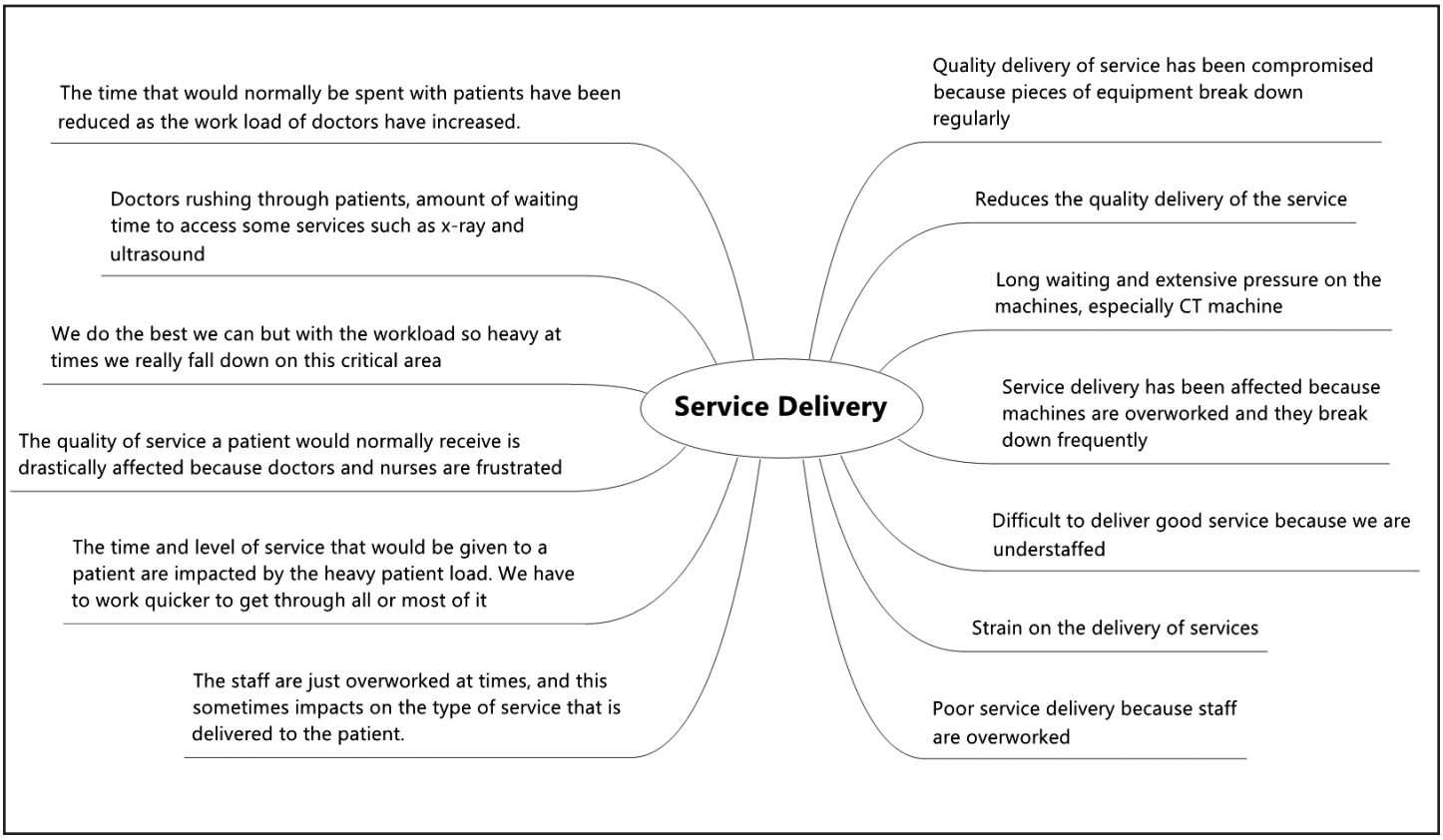
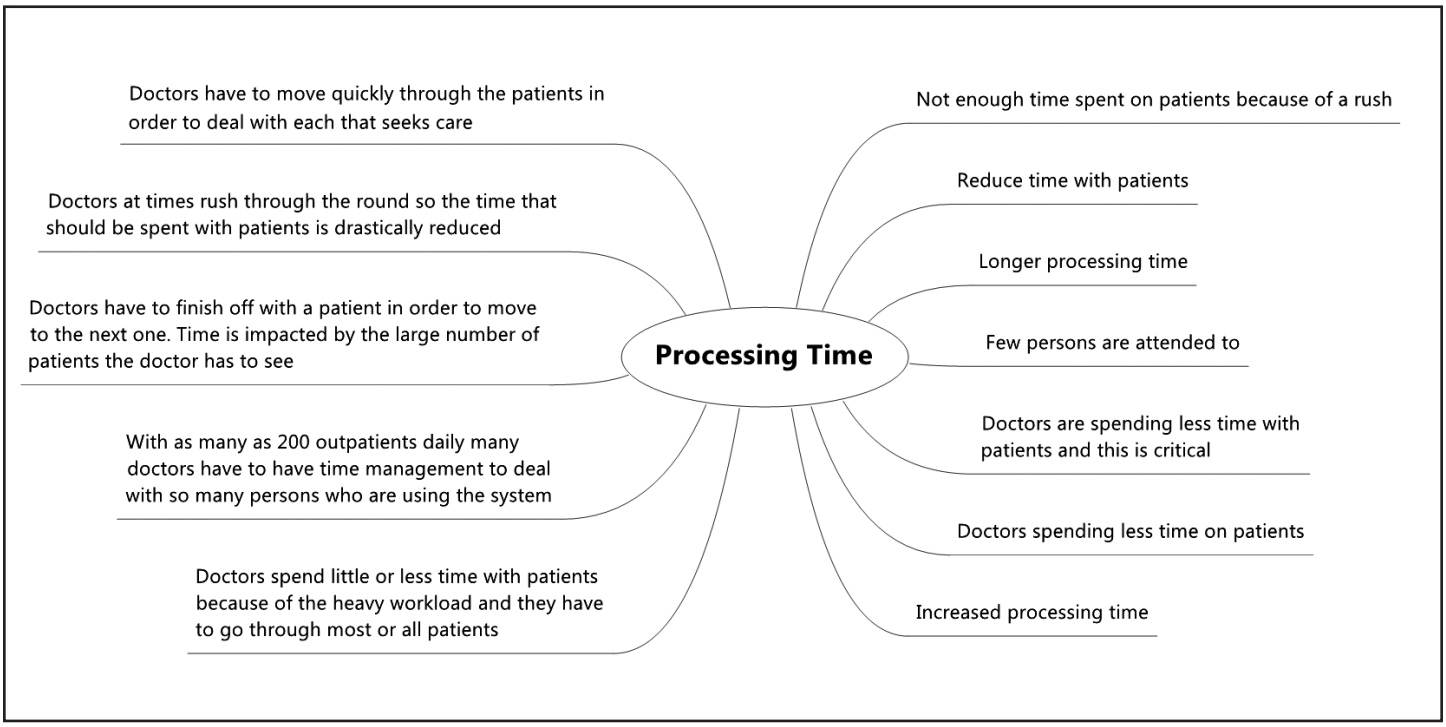


Figure 8: Effect on Processing Time of Patients



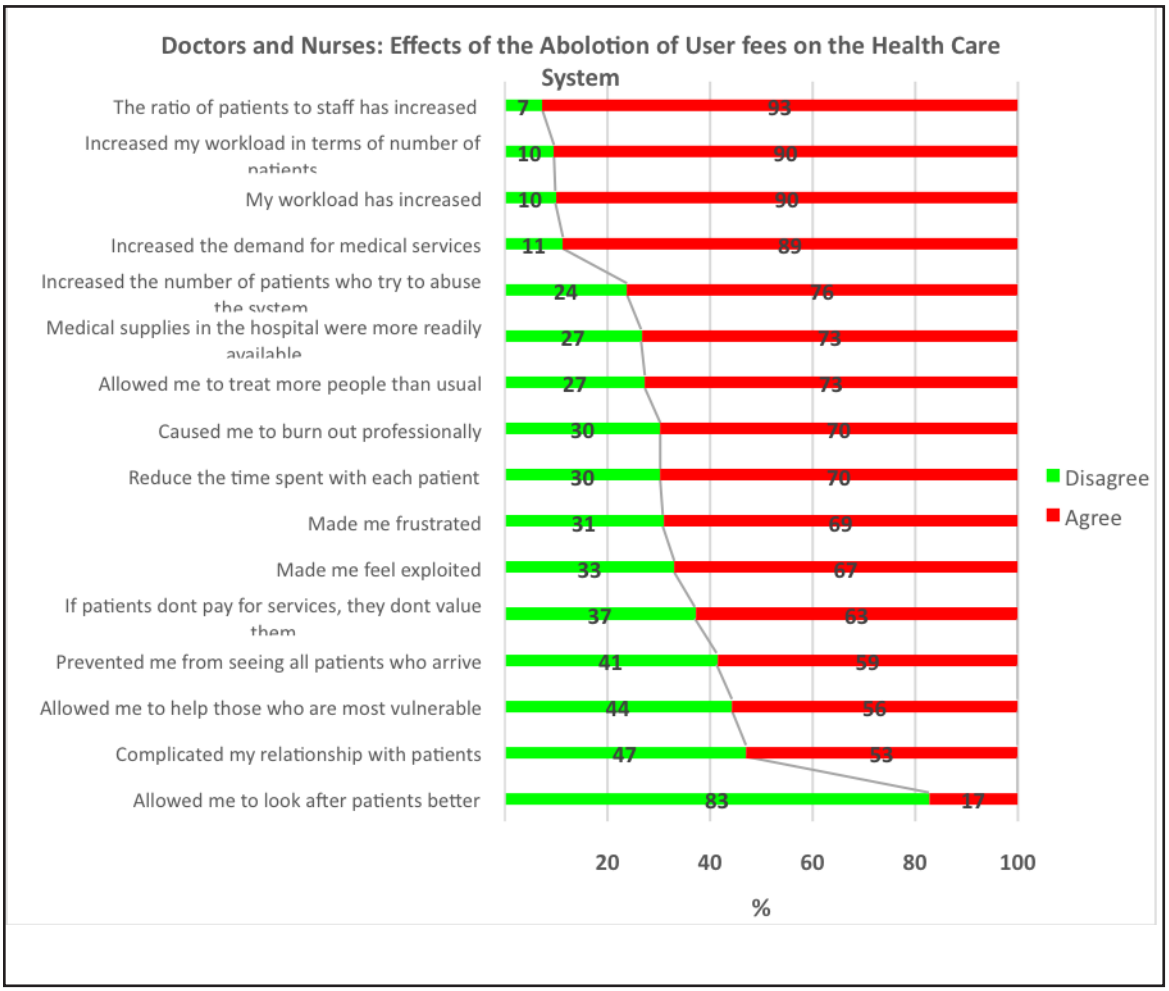
Perception of doctors and nurses on the effects of no-user fees on health care

Doctors and nurses believe that the greatest impact of the no-user fee policy on the health care is on the quality of care they provide to the patients. This is consistent with the overwhelming view that the patient to staff ratio has increased.

Impact of the no-user fees on waiting time at public hospitals

Table 2 overleaf displays the levels of central tendency with a mean of 5.6 which denotes the average, a median of 5.0 which represents the middle number, and the mode of 5.0 which signifies the most frequent response. It also showcases the value of the standard deviation 2.5, which shows the dispersion which exist from the average. Overall, the findings indicate that the respondents are moderately satisfied with the services provided at public hospitals.

Figure 9: Doctors' and Nurses' perception of the effects of no-user fees on health care

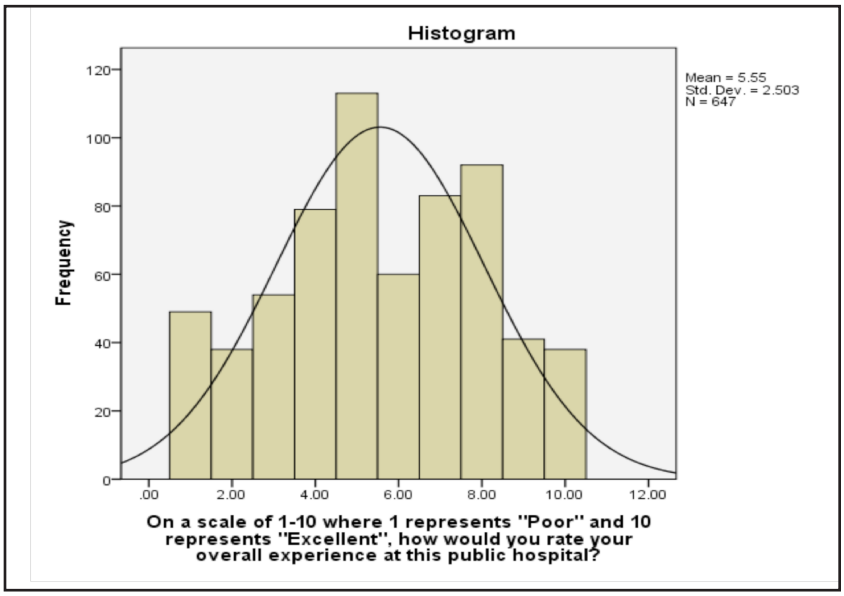


On a scale of 1-10 where 1 represents “Poor” and 10 represents “Excellent”, how would you rate your overall experience at this public hospital?

Table 2: Overall satisfaction with service at public hospitals

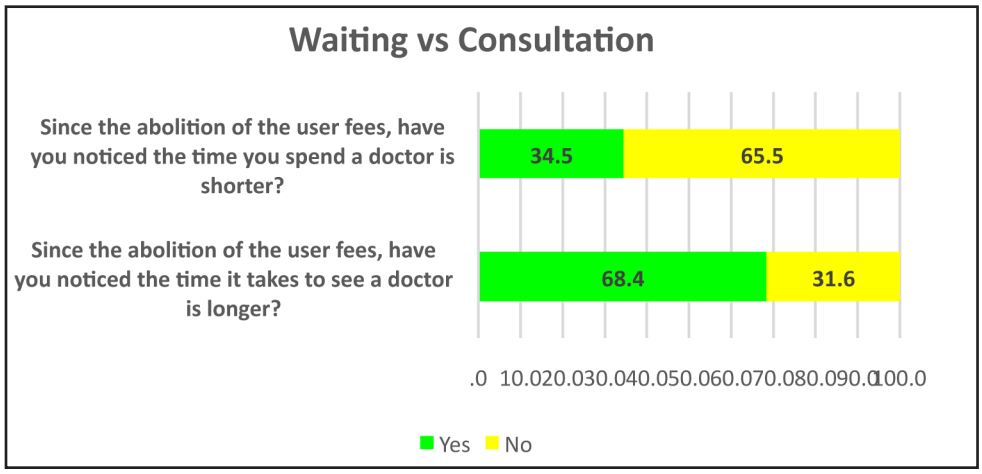
MEAN	**5.6**
MEDIAN	5.0
MODE	5.0
STD. DEVIATION	2.5
SKEWNESS	-0.1
MINIMUM	1.0
MAXIMUM	10.0

Figure 10: Overall satisfaction with service at public hospitals



A juxtaposition between patients’ perception of the waiting time and consultation since the abolition of user fees at public hospitals, revealed that more time has been spent waiting to see a doctor. This was confirmed by two thirds (68.4%) of the respondents. Where consultation time is concerned, majority (65.5%) expressed the view that time spent with a doctor has not been affected by the abolition of users fees.

Figure 11: Impact of user fees on waiting and consultation time



Responsibility for health care: doctors, nurses and patients

More than half (52%) of the sampled patients labeled the government as the primary body responsible for health care with a mere 3% charging each individual with the responsibility. In contrast 45% believe that the responsibility should be shared between the government and the individual. More than three quarters of the doctors and nurses (83%) are of the view that health care should be shared between government and the individual. Only 10% were of the view that the government should be the solely responsible while a mere 7% indicated that the patient should bear sole responsibility for health care.

Figure 13: Responsibility for Health Care- Doctors and Nurses

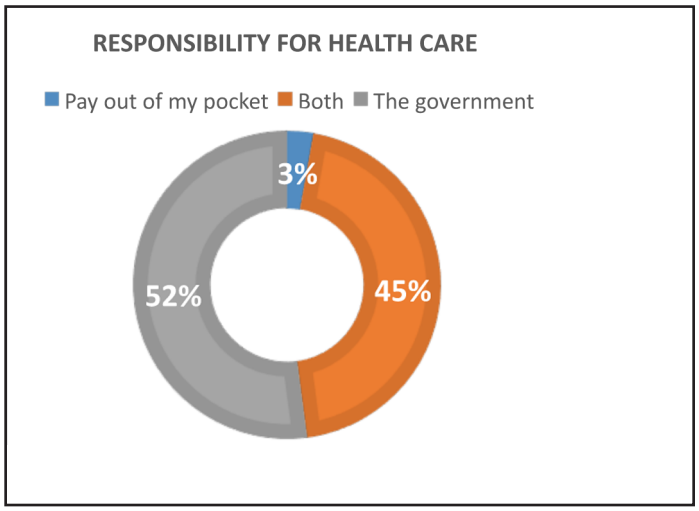
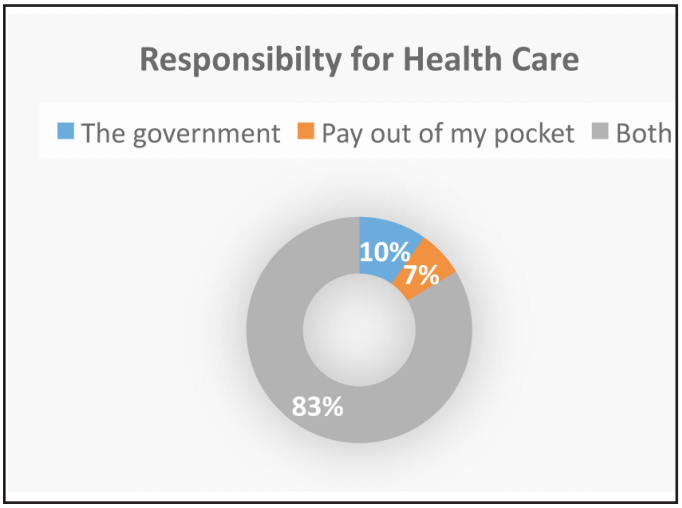


Figure 12: Responsibility for Health Care-Patient



Fee payment at hospitals from the perspective of doctors, nurses, and patients

Free Medication: Doctors and Nurses vs Patients

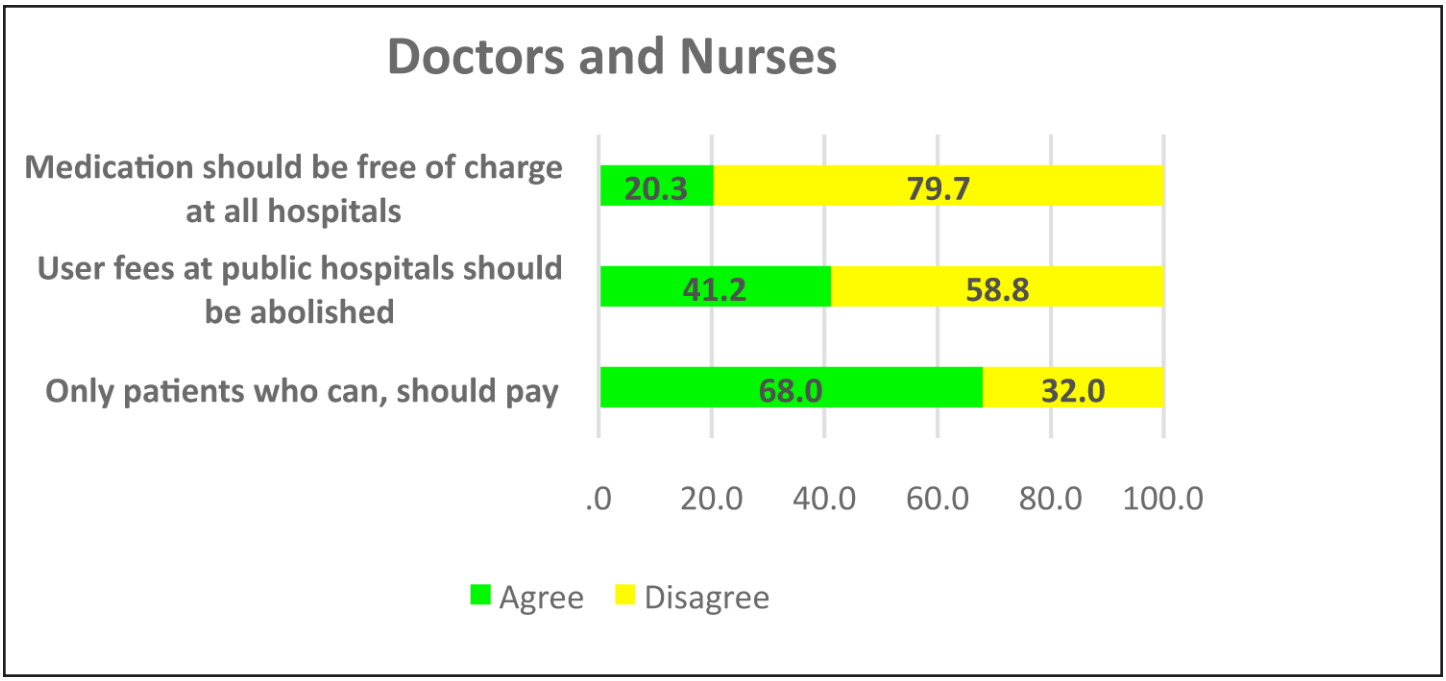
More than three quarters (79.9%) of the doctors and nurses disagreed with the view that medication should be free at all public hospitals. In contrasts, majority of the patients (64.7%) supported the view that medication should be free at all public hospitals.

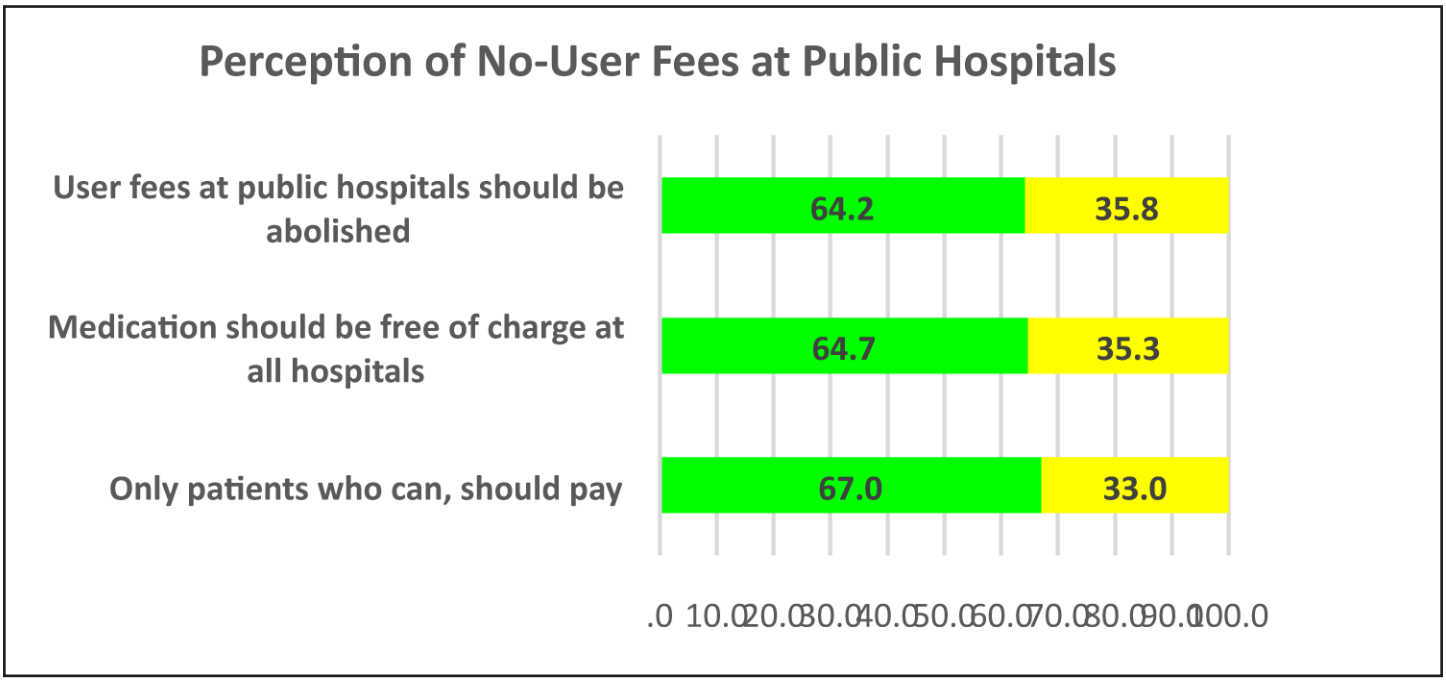
Only patient who can pay should pay: Doctors and Nurses vs Patients

Across both samples; health workers (doctors and nurses) and patients, majority of the respondents 68% and 67% respectively were of the belief that only those patients who can afford to pay should pay.

User fees at public hospitals should be abolished: Doctors and Nurses vs Patients

Among doctors and nureses, more than half (59%) of the respondents disagreed that users fees should be abolished. While among patients mmore than half (64%) agreed with the view that user fees should be abolished.


Doctors and Nurses
Medication should be free of charge at all hospitals
20.3
79.7
User fees at public hospitals should be abolished
41.2
58.8
Only patients who can, should pay
68.0
32.0
.0
20.0
40.0
60.0
80.0
100.0
Agree
Disagree


Perception of No-User Fees at Public Hospitals
User fees at public hospitals should be abolished
64.2
35.8
Medication should be free of charge at all hospitals
64.7
35.3
Only patients who can, should pay
67.0
33.0
.0
10.0
20.0
30.0
40.0
50.0
60.0
70.0
80.0
90.0
100.0

Exemption of user fees

There was shared perception among health workrs and patients as regards the exemption of certain groups from paying for health care. They believe disabled and elderly persons should not pay user fees. The views were mixed in regard to children, pregnant women and persons with HIV.

Figure 14: Doctor-Exemption from user fee

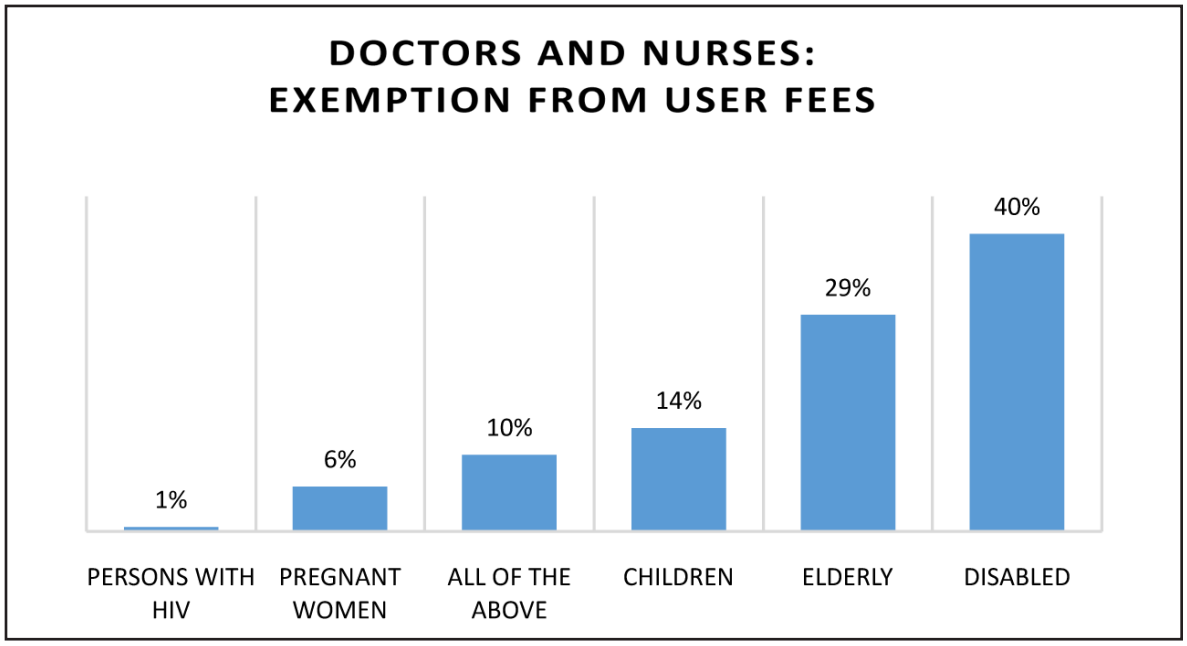
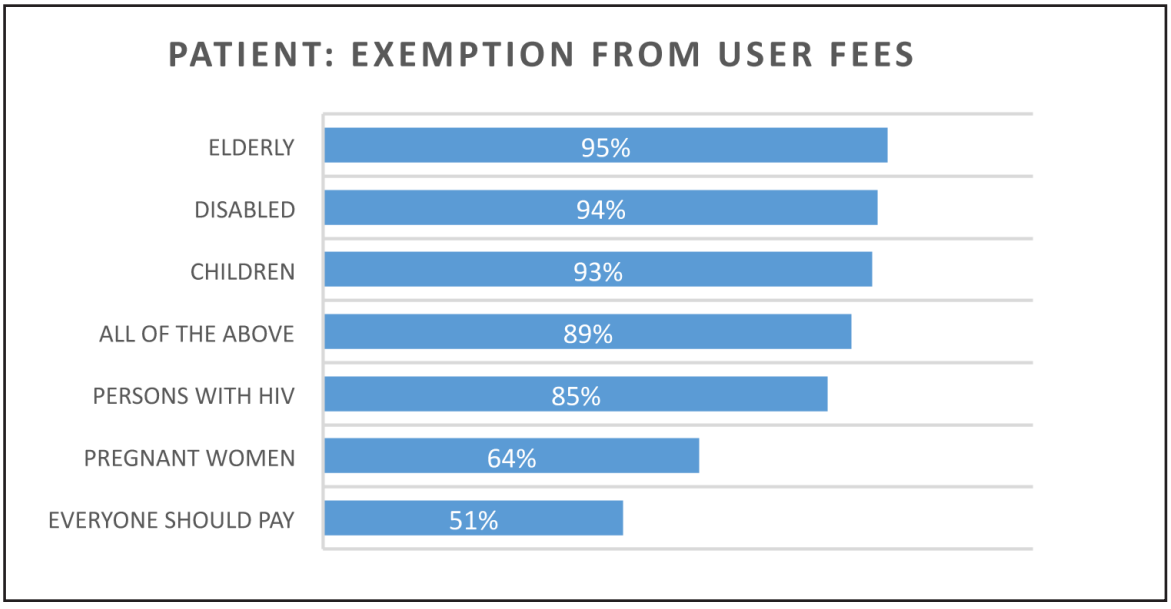


Figure 15: Patient-Exemption from user fees

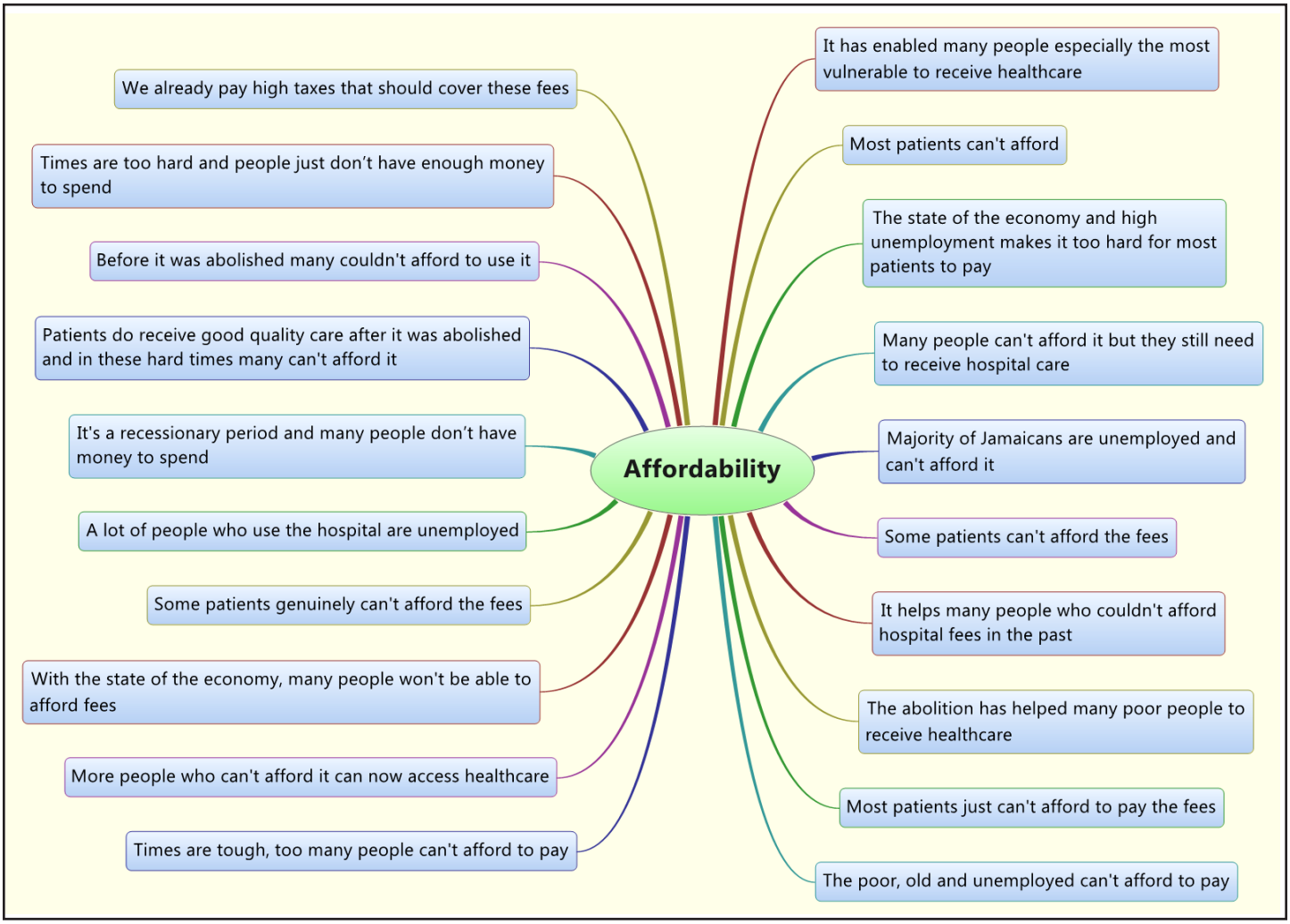


Patients' perception of the abolition of user fees

Affordability and access

Figure 16 illustrates that persons are in support of the abolition of user fees on the grounds of affordability and by extension accessibility. They lamented that many persons who are poor or unemployed will not be able to afford the services. Accessibility represents another common theme that was identified; it was pointed out that persons who previously could not afford the services are able to do so now.

Figure 16: Rationale for supporting abolition of user fees



Sustainability, waiting time and quality of service

Respondents who supported the re-introduction of user fees justified their stance on the grounds that free health care is not sustainable.

Those who support the re-introduction of user fees are of the view that the Jamaican health care system has gotten worse since the abolition of user fees. According to them, service is now ineffective and inefficient with nurses and doctors displaying an apathetic attitude towards patients and their general duties. It is also evident that the service has not only gotten progressively worse but also exceeding slow. Patients also lamented that better quality and faster service would be given if fees were paid.

Figure 17: Rationale for opposing the abolition of user fees-sustainability

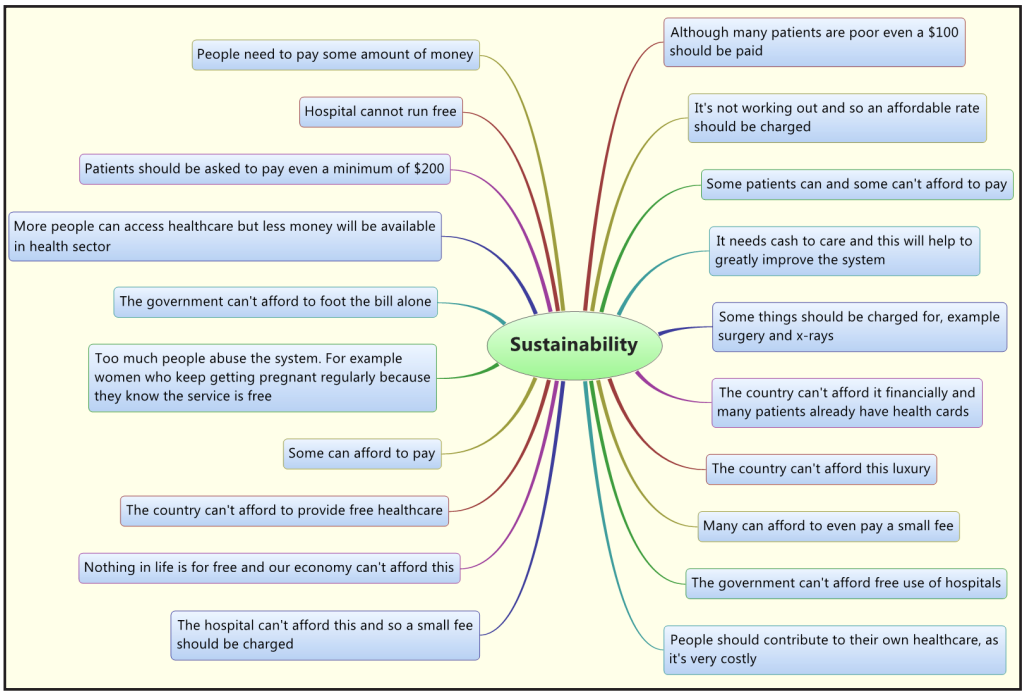
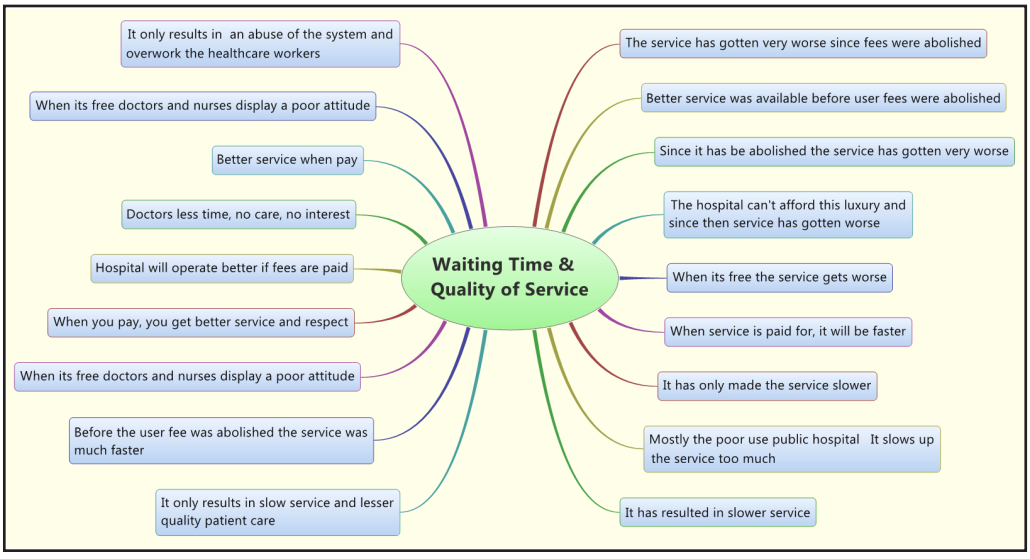


Figure 18: Rationale for opposing the abolition of user fees-waiting time and quality of service



Income and Free Health Care

The lower the person's income the more likely they are to agree to policies that will limit cost and therefore increase their spending power. This is evident where persons making low income agree to the abolition of user fees, free medication and that they should pay only if they can; 63%, 70%, and 69% respectively. Subsequently, a high percentage of middle income persons agree to fee abolition and only 'patients who can pay should pay' policy and free medication that being 66%, 67% and 55% respectively.

Of the three groups, higher wage earners are less likely to support free health care. This is so as 53% of higher wage earners disagree with the abolition of user fees with 47% agreeing. They also have 58% disagreement to free medication, whilst 42% agrees. Moreover, 61% agree that only patients who can afford to pay should pay with 39% disagreeing. When asked who's responsible for health care the lower income stratum placed this responsibility on the government while a high percentage of middle and higher wage earners, 53% and 68%, believe that it is the responsibility of both the government and the individual to maintain good health care.

Figure 19: User fees at public hospitals should be abolished-income

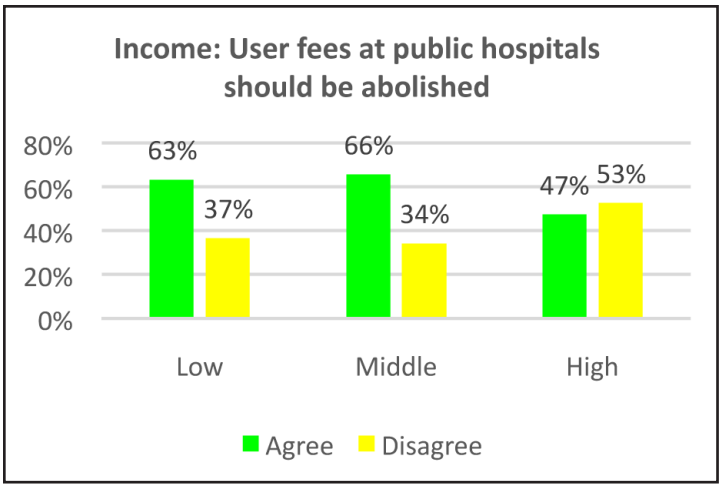


Figure 20: Responsibility for health care-income

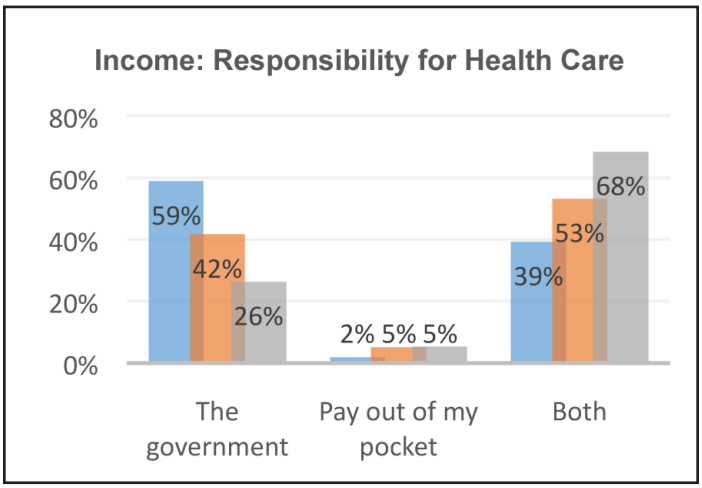


Figure 21: Medication should be free of charge at all hospitals-income

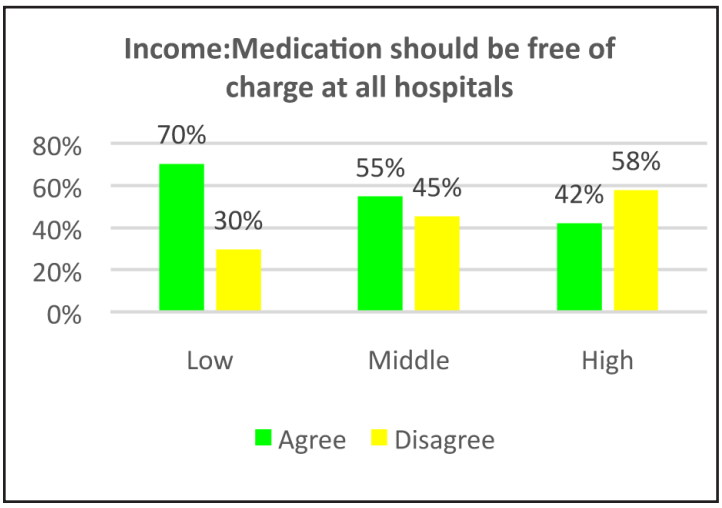
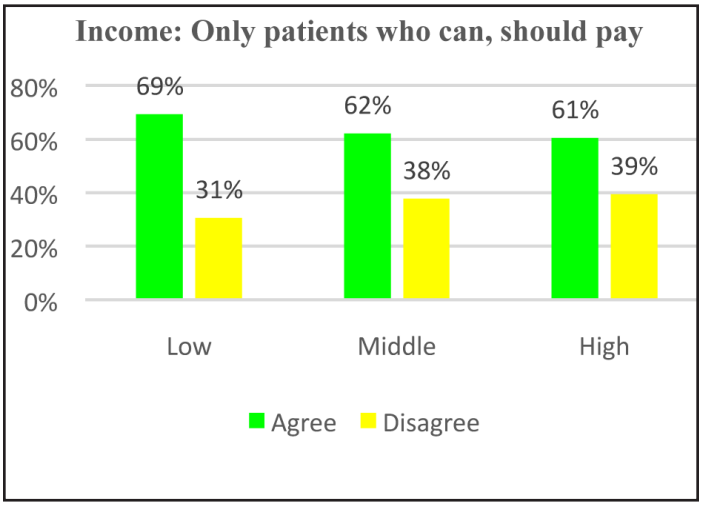


Figure 22: Only patients who can, should pay-income



Education and Free Health Care

Across all four groups, persons with no formal education (75%) were most in favor of free medication, followed by respondents with primary (69%), secondary (66%) and tertiary (52%) education. On the matter of "only those who can pay should pay", this was least favorable among respondents with tertiary education (53%), followed by respondents with no formal education (67%), secondary education (69%) and primary education (73%). The abolition of user fees when segmented across education revealed that persons with no formal education (75%) was in agreement with the abolition of user fees, followed by persons with primary (65%), secondary (66%) and tertiary (62%). When deciding who had the responsibility for health care persons with no formal education 73% placed the charge on the government. While 61% of persons educated at the tertiary level reported that the responsibility for health care was both the state's and the individual's.

Figure 23: Medication should be free of charge at all hospitals -education

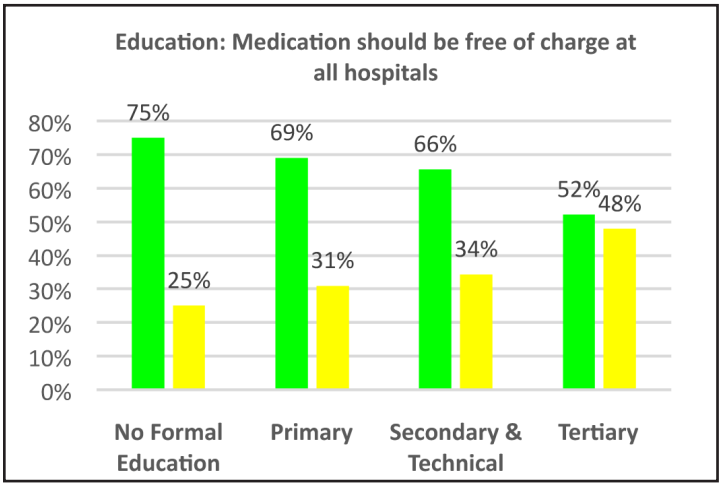


Figure 24: User fees at public hospitals should be abolished -education

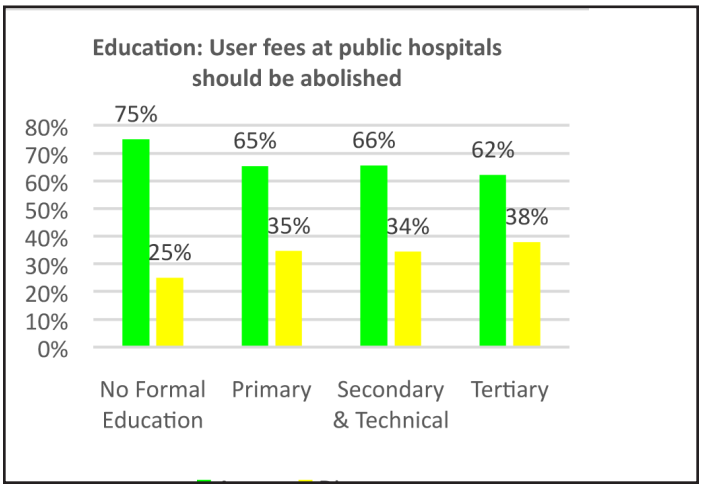


Figure 25: Responsibility for health care-education

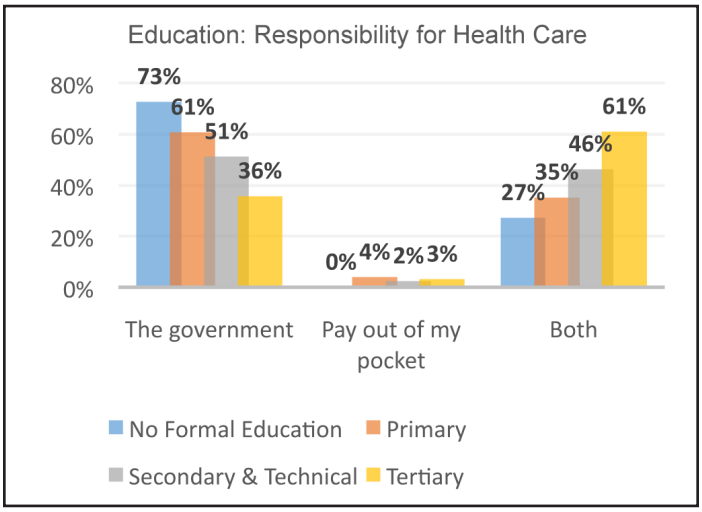
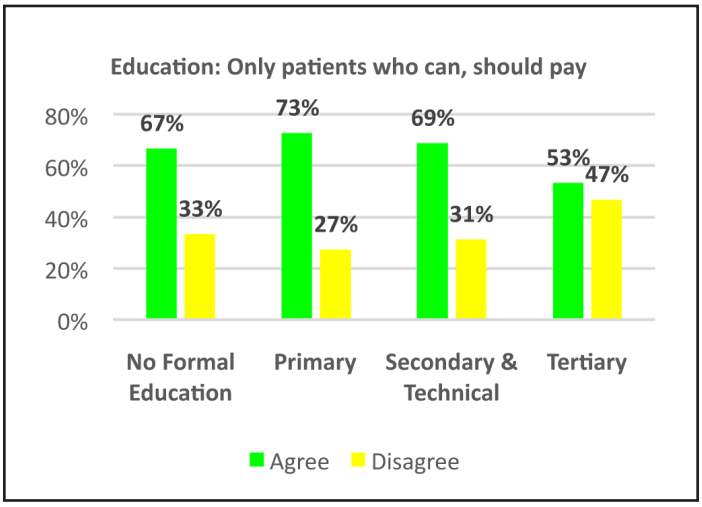


Figure 26: Only patients who can pay should pay-education



Access to insurance and free healthcare

Table 1 explains that (70%) of persons without health insurance agreed that patients who can pay should pay while the other (30%) disagreed. This is opposed to (57.1%) of persons with insurance agreeing that patients should pay if they can. This disparity was not the same when asked if user fees should be abolished in its entirety, a majority of both insured and uninsured agreed accounting for (61%) and (65%) respectively while the other (39%) and (35%) respectively disagreed. 68% of the uninsured agreed that medication should be free at all hospitals, whilst (32%) disagreed; in contrast (57%) of insured person agreed that medication should be free whereas (43%) disagreed.

Fig 27: Only patients who can pay should pay-insurance

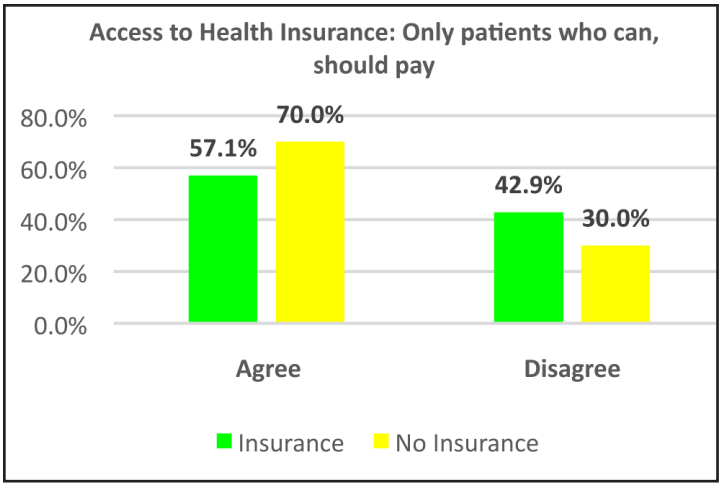


Fig 28: Medication should be free of charge at all hospitals-insurance

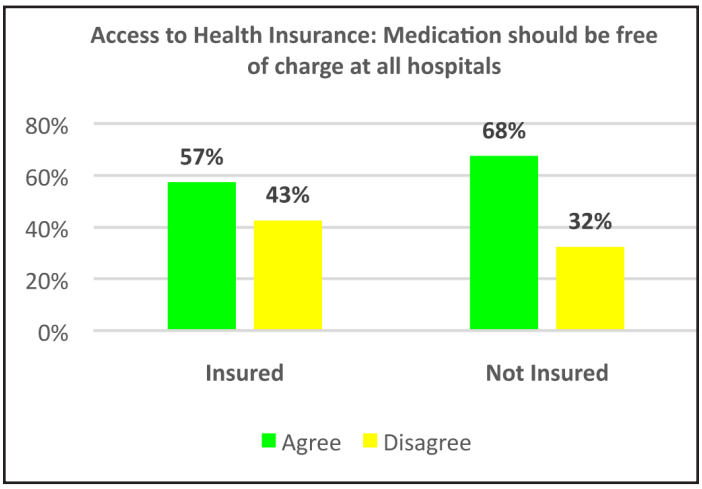
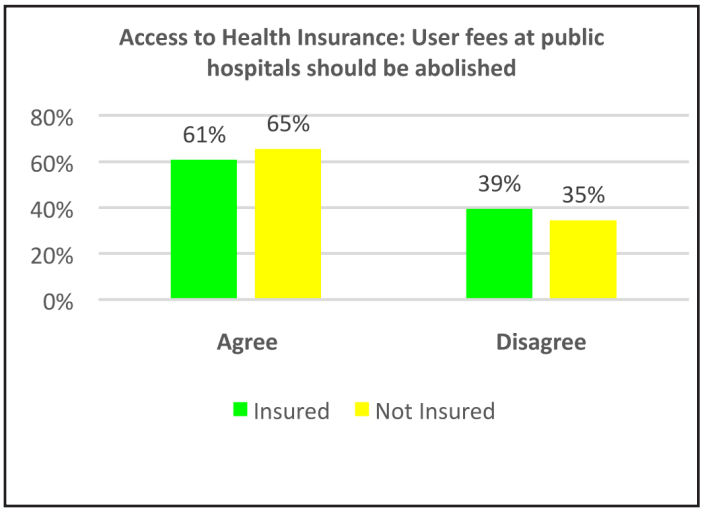


Fig 29: User fees at public hospitals should be abolished-insurance



Demographics of persons who access and use public hospitals

In the case of gender, females (54.0%) tend to use public hospitals more than males (46.0%), whereas the age groups showed that adults between 25 and 64 make greater use (77.5 %) of public hospitals while the elderly represented the group with the least reported access and use of public hospitals. It was observed that persons with higher income did not readily access and use public hospital. Level of education also played a role in the rate at which persons used the public hospital. Persons who have tertiary education and persons with no formal education account for the lowest use of public hospitals, 14.9% and 1.9% respectively. Individuals with secondary and primary education accounted for 58.5% and 24% respectively of persons who utilized public hospitals. Finally, persons who have health insurance did not utilize the services of the public hospitals as did persons without health insurance.

Table 3: Demographics of persons who access and use public hospitals

Variable		Frequency	Percent (%)
Gender	Male	301	46.0
	Female	353	54.0
Age Group	Youth (18-24)	102	16.0
	Adult (25-64)	495	77.5
	Elderly 65-Over	42	6.6
Income	Under 50,000	365	62.9
	50,000-109,000	177	30.5
	110,000 and over	38	6.6
Highest Education	No formal education	12	1.9
	Primary	159	24.7
	Secondary	376	58.5
	Tertiary	96	14.9
Health Insurance	Yes	151	23.7
	No	485	76.3

Majority (59%) of the respondents stated that they visit the doctor when it is necessary; followed by 15% admitting to visiting the doctor once every six months, whereas nine percent of respondents visited the doctor once per month. Eight percent visited once every other month, 6 percent visits the doctor once per year; whereas 2% go to see the doctor every other week, while one percent visits the doctor one to three times per week.

Hypertension was reported to be the most frequent sickness suffered from at 40% followed by diabetes 23%, chronic pain 14%, chronic respiratory-related diseases 10%, cardiovascular 4%, cancer 4%, sickle cell 2%, thyroid complications 2% and epilepsy 1%.

Figure 30: Frequency of Hospital Visits

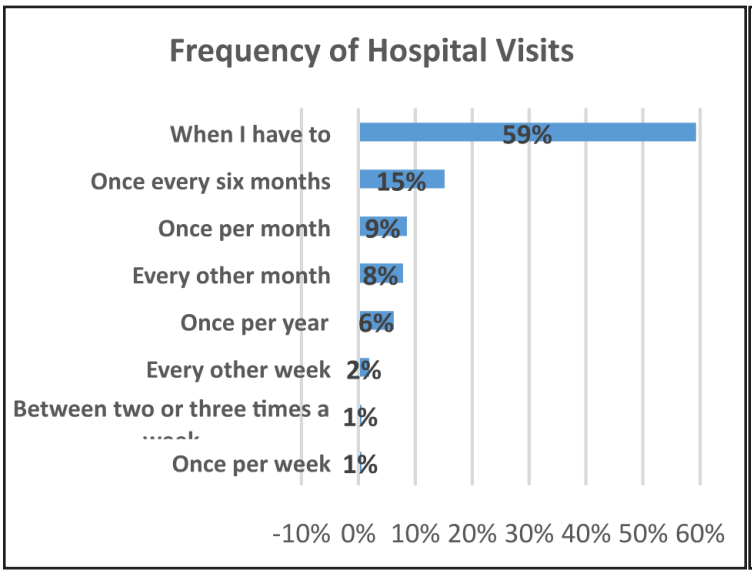
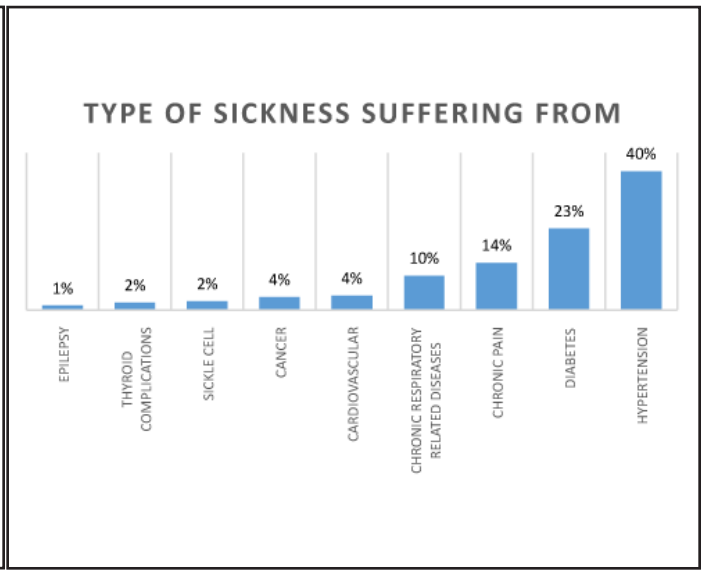


Figure 31: Type of sickness suffering from

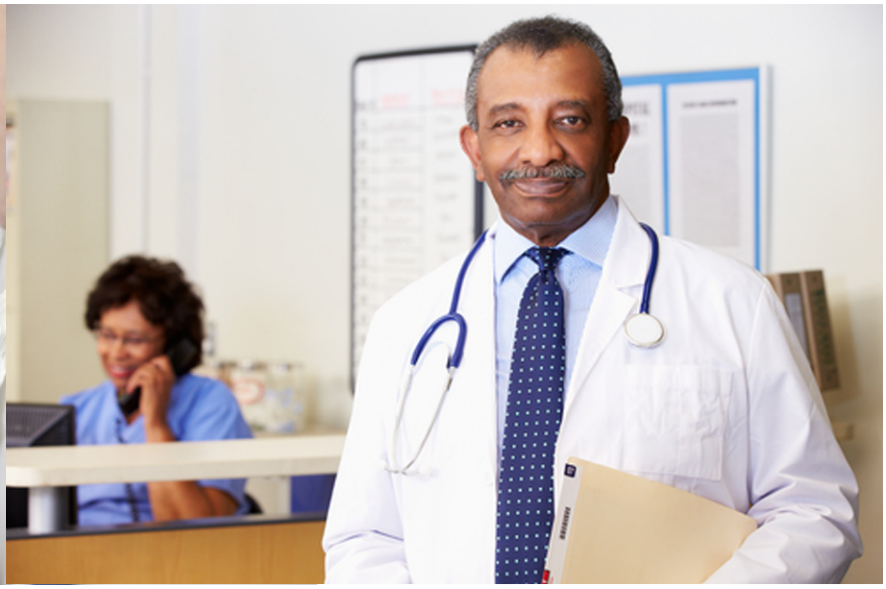


Conclusion

The removal of user fees was introduced as a means to increase access to care but it is not an end in itself. In this regard, the population favours a no-user fee policy but health workers are worried about its sustainability based on the unintended outcomes of the system.

If the policy is to be maintained it must be twinned with a package of reforms that address longer term health systems issues in particular adequate financial resources, health worker availability and performance and drug supply chain management. This is essential if the poorest patients are to really benefit.

As the future for the policy remains unclear, it is important to establish and monitor whether previously exempt groups are crowded out by new users, and whether the additional utilization is due to new people accessing services or whether it is previous users accessing services more frequently. In addition, it is worth studying the impact that the policy has had on the overall 'health of the nation' and whether or not there has been an increase on preventive health care.



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