

VIEWPOINT

The Impact of a No-user-fee Policy on the Quality of Patient Care/Service Delivery in Jamaica

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ABSTRACT

This paper is a submission to the Sessional Select Committee on Human Resources and Social Development by the Medical Association of Jamaica on September 25, 2011, and presented orally by both authors on October 20, 2011. It explores the impact of the no-user-fee policy on the quality of patient care/service delivery in Jamaica and makes recommendations for reform.

Keywords: No-user-fee policy, quality of patient care, service delivery

Impacto de una Política de Gratuidad para el Usuario Sobre la Calidad de la Atención al Paciente y la Prestación de Servicios

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RESUMEN

Este trabajo es una presentación al llamado Sessional Select Committee en torno a los Recursos Humanos y el Desarrollo Social, realizada por la Asociación Médica de Jamaica el 25 de septiembre de 2011, presentada oralmente por ambos autores el 20 de octubre de 2011. Explora el impacto de una política de gratuidad para el usuario sobre la calidad de la atención al paciente y la prestación de servicios y hace recomendaciones en cuanto a realizar reformas.

Palabras claves: Política de gratuidad, calidad de la atención al paciente, prestación de servicios

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INTRODUCTION

We would like to state at the outset of this submission/presentation, that no member of the team which compiled this report is a member of any political party in Jamaica. The Medical Association of Jamaica (MAJ) receives no funding from the Ministry of Health (MOH). This is a presentation of our views on the impact of the no-user-fee policy on the quality of patient care/service delivery and recommendations for reform. This is an area which is intricately intertwined with the many challenges faced in the Jamaican health sector. We think it is important to point out that a number of these challenges were present before and have continued with the current political administration. We will be providing, as a background to our discussion, an overview of the challenges as we see them, then narrow our focus on the issues associated with the no-user-fee policy, including recommendations.

The MAJ empathizes with the current economic challenges being faced by Jamaica. It recognizes the need to implement cost-saving measures throughout the country. However, any proposed cost-saving measure which has the potential to adversely affect patient care and health service delivery in Jamaica cannot be supported by the medical fraternity. The MAJ recognizes the benefits of increased access to physicians and medication, when available. We are aware of the contribution being made by all hard-working members of the healthcare team (MOH, Regional Health Authorities, primary care, administrative managers *etc.*). We also recognize the work being done to enable Jamaica to achieve the Millennium Development Goals and the targets set for Vision 2030. Most importantly, the MAJ supports the increased attention being given to the issue of health policy and reform of the health sector.

Data to inform our opinion have been obtained from the following:

1. Over 100 accumulated years of service to the Jamaican health sector, both public and private, by members of the team participating in discussions about the no-user-fee policy.
2. Over 13 accumulated years of experience by the authors, utilizing health services and living in countries with functional no-user-fee policies for the provision of healthcare to their citizens.
3. Discussions at various points over the last two years with colleagues on the ground (consultants, residents, house officers and interns) working in hospitals and health centres throughout the length and breadth of Jamaica.
4. Discussions at numerous meetings with teams from the MOH, primarily those held in the last four years.
5. A review of many years of media publications on the health services in Jamaica.

6. A review of news releases and responses to the MOH from the MAJ.
7. A review of studies and country reports on the Jamaican health sector by local and international entities over the last 20 years.

History and Structure of the MAJ

The Medical Association of Jamaica is the oldest professional association in Jamaica, having been constituted as the first overseas branch of the British Medical Association in 1877. After independence, the MAJ was formed to replace that body. There are now over 2000 members, including medical students, representing all specialties.

The MAJ is the umbrella organization for all professional medical associations and societies (total 22) in Jamaica, with a representative elected from each to sit on the MAJ Council. Past presidents, branch chairmen and chairmen of MAJ committees also sit on the Council.

The Ministry of Health's Objectives

The Ministry of Health's objectives (1) are to:

- * Promote wellness and protect the health of the Jamaican population;
- * Improve individual health outcome by ensuring access to effective, affordable and equitable health-care services;
- * Improve the quality of healthcare provided to the nation;
- * Improve the Ministry of Health's ability to prepare for, and respond to health threats from man-made and natural disasters;
- * Strengthen the leadership and management of the Ministry of Health to achieve its objectives;
- * Develop a national health policy and strategic plan;
- * Redesign the national health service system for greater efficiency and effectiveness;
- * Recognize the critical importance of information and communication technologies to enable the realization of the objectives of the national health policy and strategic plan.

The MAJ is quite concerned that many of these objectives have not been met. We will proceed to outline the reasons as symptoms of a health sector in crisis, which includes our focus on the impact of the no-user-fee policy on the quality of patient care/service delivery.

Symptoms of a Health Sector in Crisis

1. Inadequate budgetary support for the MOH which has resulted in poorly staffed and poorly stocked healthcare facilities. This underfunding has resulted in a deterioration of the Jamaican health sector (2).
2. Cost of healthcare not aligned with patient outcomes, primarily because of the lack of a patient-focussed approach to the delivery of health services.
3. A dysfunctional health reform process (regionaliza-

tion) which has demonstrated the following (3):

- * disproportionate expenditure on administration to the detriment of clinical services
 - * poor functional and structural organization with obscuring of clinical and administrative functions leading to questionable decision-making processes, with the potential for increased morbidity and mortality
 - * lack of cohesion and cohesiveness between the regions
 - * lack of dialogue and participation in the decision-making processes across the sector
 - * crises oriented communication/knee jerk responses, usually followed by a MOH news release that a meeting was held to address issues
 - * poor implementation of changes, including the no-user-fee policy
 - * ageing and poorly maintained medical equipment and physical plants
 - * inadequate service delivery spaces especially in inaccessible rural areas
4. Poor working conditions and the absence of opportunity for promotion resulting in disillusion and apathy among all healthcare providers (4).
 5. Inadequate numbers of doctors in the primary care system, primarily due to the inability of the MOH to attract and keep doctors in these areas (lack of incentives).
 6. Inadequate numbers of specialist-trained doctors due to the lack of appropriate number of posts in the public sector. In some areas, the establishment has not been increased in the last 30 years. Many physicians who completed their specialty training many years ago are working as grade II doctors, not as consultants. No hope was expressed by physicians at Kingston Public Hospital (KPH) that this situation of unavailability of posts will be rectified in the near future. The general sentiment expressed is that the regional health authority (RHA) does not care, provided the work is done (5).
 7. Inadequate forensic and other pathology services which could impact negatively on the quality of medico-legal investigations.
 8. Chronic shortage of technical staff.
 9. The high prevalence of preventable injuries being treated at our hospital due to violence and avoidable accidents.
 10. Issues with inadequate ambulance services at healthcare facilities.
 11. Violence toward physicians and other healthcare workers in the system, primarily the result of poor security measures in healthcare facilities.
 12. Lack of political will to implement well proven measures known to reduce the incidence and

prevalence of non-communicable diseases (NCD), *eg* no-smoking legislation.

13. A flawed health sector reclassification exercise, resulting in increased levels of dissatisfaction amongst healthcare workers (2, 4).
14. Over the last two decades, there has been continuous erosion of the doctor's role regarding the formulation and implementation of health policies and the delivery of healthcare in Jamaica.
15. A flawed reporting structure of the Chief Medical Officer (CMO), who now reports to the Permanent Secretary of the MOH, with no direct communication with the Minister of Health. The CMO is the chief technical advisor to the Minister of Health, not to the staff of the MOH.
16. Experiences with the challenges associated with the abolition of user fees for children in 2007.

In the midst of all the above, we then had a general election in Jamaica with many promises being made. This led to the speedy implementation of a widespread no-user-fee policy in April 2008, soon after the general election.

Given the lessons learnt from the abolition of user fees for children in 2007, the MAJ anticipated many challenges, which were discussed at length in a meeting between MAJ and the then Prime Minister of Jamaica, the Honourable Bruce Golding, at Jamaica House on February 7, 2008 (6). In this meeting, we outlined the fact that an increase in patients attending the outpatient departments of all hospitals would:

- i. Overwhelm the services including consultation, nursing, laboratory and X-ray services
 - ii. Increase the waiting time for patients to see the doctor
 - iii. Overwhelm the spaces provided for the Accident and Emergency and Casualty Departments
 - iv. Consume the supplies and sundries including pharmaceutical supplies
 - v. Result in frustration and violence directed at health personnel (displaced aggression)
17. The deterioration of the primary healthcare system, its underutilization and the drift of patients from the primary healthcare to the secondary healthcare system, resulting in an inappropriate usage of the health dollar (6).
Deterioration in the areas of:
 - vi. Pharmaceutical supplies and the dispensing of drugs
 - vii. Chronic unavailability of supplies and sundries, including laboratory, radiological and pharmaceutical supplies

- viii. Insensitive opening and closing times that do not fulfil the needs of the patients
 - ix. Inadequacy of numbers of health personnel including nurses and doctors
18. Lack of a sustained and effective education campaign by MOH on the use of hospitals and health centres by those in need.
 19. Recognition of the need to address a number of these issues, prior to any further implementation of a widespread no-user-fee policy, *eg* upgrading primary care services, adequate staffing for these services, improving working conditions in primary care facilities, educating the public about the appropriate use of hospitals *etc* (6).
 20. Repeated calls by the MAJ for the Government to invite all stakeholders in the healthcare system to engage in dialogue related to cost-saving measures for the health sector so decisions can be made, based on scientific evidence (2, 4).

The Impact of the No-user-fee Policy on the Quality of Patient Care/Service Delivery

1. The demands placed on the already resource constrained health service with the introduction of the widespread no-user-fee policy now stretched the system to a breaking point, as anticipated by many working in the health sector.
2. The increased cost of healthcare associated with this increased demand, in addition to the already inadequate budgetary support, lost income from those who would normally pay and the discontinuation of income from those covered by health insurances, rendered the situation even more acute. Additional funds injected to offset these areas of lost earnings were not adequate enough to ensure the smooth running of the health service.
3. Increased demand for medical services, leading to additional workload for inadequately staffed health facilities (7).
4. High patient to doctor ratio, with no adequate increase in the number of physicians in Casualty areas. The introduction of abolition of user fees, though welcomed, was seen as a major contributor to this (5).
5. The waiting period for non-emergencies was far too long. Much longer than the desired, beyond acceptable standards and completely unsatisfactory (6–8 hours in many hospitals, *eg* Bustamante Hospital for Children) based on international standards (5, 8). Physicians in the clinics empathized with the dissatisfaction expressed by patients about the long waiting period but assured the MAJ President that they were doing the best they could with the available resources.
6. Demoralized staff: Physicians working at KPH appeared to be demoralized with the present conditions under which they worked (5).

7. Reports of repeated complaints to the authorities. The general feeling expressed was that the current system of the RHA was ineffective (5).
8. Attempts to minimize the significant longstanding issue of inadequate and unrealistic budgetary support for the MOH (4).

The lack of adequate numbers of physicians employed in some areas and at some hospitals has resulted in a few physicians working extraordinarily long hours, for which they are compensated. It is therefore unfair to use these exceptions to the norm, resulting from fewer physicians being employed than required, to scapegoat the dedicated and hard-working doctors in the country. Indeed a large proportion of physicians at hospitals work outside of their scheduled hours without compensation. Doctors get the lowest rates for overtime and emergency services.

Statements of this nature (“overtime windfall”) only serve to minimize the significant, longstanding issue of inadequate and unrealistic budgetary support for the MOH. The current system of staff allocation for routine, as well as emergency services has been proven over the years to be the most effective method of healthcare delivery in a system with severe shortages such as ours, *cf* a “shift system” (4).

9. The derailment of strategies in the 2006–2010 MOH strategic plan with the sudden introduction of the no-user-fee policy.

MAJ Recommendations for Reform

1. The adoption of and adherence to international standards of health service delivery, including quality of and access to healthcare.
2. That the Minister of Health invites all stakeholders in the healthcare system to engage in meaningful dialogue about the many challenges being faced by the health sector so decisions can be made based on scientific evidence. Regularly scheduled meetings (every 2–3 months) should be held.

The MAJ has taken the lead in forming a Joint Health Sector Group (JHSG), facilitating discussion between colleagues who face common challenges in the Jamaican health sector. Members include the Jamaica Medical Doctors Association (JMDA), Pharmaceutical Society of Jamaica (PSJ), Association of Government Medical Consultants (AGMC), Jamaica Physiotherapy Association (JPA), Jamaica Association of Professionals in Nutrition and Dietetics (JAPINAD), Jamaica Association of Public Dental Surgeons (JAPDS) and the MAJ.

3. A satisfaction survey (for patients and healthcare workers) on the impact of the abolition of user fees on hospitals like KPH should be commissioned immediately (include quality of service, service required vs service received, prescriptions received, waiting period *etc*).
4. Improve working conditions of healthcare providers in the public sector.
5. Establish workload indicators for staff.
6. Establish clear standards for doctor/patient ratios in health facilities which will prevent staff burnout and poor delivery of service.
7. Continue the no-user-fee policy for all in health centres.
8. Continue the no-user-fee policy for children, the elderly, the physically and mentally challenged.
9. Redevelopment of policy guidelines to implement the no-user-fee policy for those eligible.
10. That the Government review the need to provide complete treatment at the hospitals for those accessing the no-user-fee services. Currently, patients are required to purchase items outside the facility from private suppliers in order to finalise treatment (*eg* Orthopaedics – pins and screws, various laboratory investigations).
11. Restore realistic user fees outside the categories mentioned in items 7–8 above – voluntary, compulsory, incidental.
12. Develop, in consultation with the medical fraternity, a “package/basket” of no-fee investigations and procedures for those unable to pay.
13. Put systems in place based on ability to pay. Healthcare institutions would continue to bill insurance companies using clients’ insurance cards.
14. Improve diagnostic services for primary care.
15. Increase the number of physicians working in primary care through a combination of improved incentives and the employment of physicians from overseas (*eg* Cuba) where local physicians are not available.
16. Extended hours for service delivery in primary care facilities. A logical response to the increased number of patients we would like to encourage to access primary care services.
17. Establish appropriate referral systems from primary care centres to secondary or tertiary care facilities.
18. The high incidence and prevalence of preventable injuries (motor vehicle accidents, interpersonal conflict, substance abuse associated) need to be addressed, as this is a major source of expenditure. Need for clear targets and timelines for implementation of measures to target these areas.
19. That the Government establish a clear development plan for specialist areas, including post graduate (DM) training and the provision of adequate resources to facilitate this. This area should be developed along with “Centres of Excellence” for the delivery of services, particularly in the rural areas where these are not currently available.
20. Urgently expand the number of posts available in the public health sector in keeping with the strategic objectives of the redesigned national health service system.
These should include:
 - a. Specialist-trained and other Doctors
 - b. Junior Doctors
 - c. Nurses
 - d. Medical Technologists
 - e. Pharmacists
 - f. Physical Therapists
 - g. Radiographers
 - h. Dieticians
 - i. Others
21. That the Government initiate an urgent review of the health reform process to address the ineffectiveness of regionalization of health planning, service delivery, accountability, transparency, communication and community involvement.
22. That a broad commission be established to rescind the decentralization model to reduce administrative cost.
23. That the Government make available to the Jamaican people and implement, as a matter of urgency, the recommendations of the review of the RHA by Professor Winston Davidson.
24. The Health Minister mandated “A comprehensive review and evaluation of the Regional Health Authorities and their related entities, with recommendations on the way forward to a cost-effective, comprehensive and sustainable healthcare delivery system for Jamaica in the 21st Century” (9). This review was prepared by the Health Sector Task Force (2007), chaired by Professor Winston Davidson. The document has been completed for some time now.
25. That the Government prioritize the implementation of a National Health Information System as an essential and necessary strategy to improve the efficacy and the effectiveness of the national health service system.
26. That the application of information and communication technology be used in the development of centres of excellence within the public sector, in collaboration with the private sector, to enable the export of services and the development of health tourism. Upgrade specialty hospitals to world class standards and tap into the global world tourism market. The proceeds from these services may be used to support financing of the public health sector.
27. That the MAJ would support a lobby by the Minister of Health to the Minister of Finance and the Prime Minister to provide greater budgetary support for health.

28. That the Government realign cost of healthcare with patient outcomes.
29. That the Government increase collaboration with private health facilities and other specialist centres to provide specialized services for public sector patients by establishing a duty-free concession protocol for diagnostic equipment.
30. That the National Health Fund explore the possibility of including other chronic diseases which significantly impact on the health of the Jamaican people, and that they be guided by epidemiological research data.
31. Public Education/Communication Plan: a vital component of the implementation plan will be the public education programme. This programme prepares the public for the impending changes, not only in fee payments, but it also manages the public expectations on service delivery. The Ministry's Public Relations Department should spearhead this effort.

As you have seen, the concerns of the MAJ are far wider than the issue of user-fee abolition. We are very clear that healthcare can never be a production line, where we try to maximise the numbers utilizing the available services, independent of the quality of services being offered, or the needs of the patients. The patient must always be the centre of focus and the necessary services required, for a fee, or no fee, built around him/her. The state of healthcare in Jamaica is in a crisis. The MAJ is committed to finding solutions to

improve patient care and health service delivery in Jamaica. This can only come through team work. We stand ready to work with any Government of Jamaica. We close with the VISION of the MAJ:

Quality, Affordable, Patient-focussed Healthcare for All Jamaicans.

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