FINANCING PUBLIC HOSPITALS IN GHANA

BY

DR. DANIEL ASARE

Ag. CEO, CAPE COAST TEACHING HOSPITAL

HEALTH SUMMIT - GIMPA

12th MAY 2015

BRIEF OUTLINE

- Introduction
- Current Situation on Financing of Public Hospitals
- Key issues in Hospital Financing in Ghana
- Sustainable Hospital Financing
- Conclusion/ Recommendations

INTRODUCTION

Hospitals cost huge funds to construct, they require funds to operate and they need budget to maintain. The trinity of balance must be maintained at all times. Else quality and safety to patients are compromised.

- *The Higher the level of care the higher the cost of running and maintaining the facility.*
- *The older the facility the higher the cost of maintenance,*
- *Similarly, the older the equipment the higher the recurrent cost.*

FINANCING SOURCES OF PUBLIC HOSPITALS IN GHANA

Public Hospitals are financed through multiple sources. These include;

1. **Government of Ghana**- GOG funds are provided for salaries of full time employees, capital investments.

2. **Internally Generated Fund(IGF)**

a) **Health Insurance** – The NHIS has become a major purchaser of Hospital services with 70%-90% of OPD/Inpatient client registered with the scheme. Through various methods – DRG, with fee for service for medicines, capitation payment in Ashanti Region.

This reimbursement constitutes only 20% of the cost of services.(exclude salaries, Capital investment, cost of utilities, equipment cost, training and research costs)

Payment has always been associated with long delays. Current delay is long but not unusual.

FINANCING SOURCES OF PUBLIC HOSPITALS IN GHANA

IGF

b) User fees "cash and carry" which is direct payment from non-insured or services outside the NHIS benefit package eg. Dialysis, mortuary, e.t.c.

This is a more reliable source of revenue for Hospitals. It constitutes between 10-20% of total IGF revenue.

"This is the life wire in the current crises"

FINANCING SOURCES OF PUBLIC HOSPITALS IN GHANA (cont'd)

IGF is used to finance several activities both recurrent and capital including ;

- Procurement of medicines and non medicine commodities
- Logistics and Basic equipments
- X'ray, Generator sets, vehicles, repair of morgue, construction of wards e.t.c
- Salaries of casual staff – which is growing, allowances of employees(e.g (Fuel, car maintenance, transfer grants, honorarium, are all paid from IGF)
- Training of staff, In service, Post Basic, Post Graduate trainings are all from IGF
- Maintenance of equipments, infrastructure, outsourced service charges, Utilities, electricity, water, telephone, internet broadband

3. **Donor fund** – in the past Hospitals were allocated donor pooled funds for service delivery and other operations but this funds have stopped for the last 6-7 years. Donor funds to Hospitals now come in support of programmes like; Malaria, Ebola, HIV/AIDS and TB

4. **Donations** – Hospitals seldom receive donations of beds, medicines, equipments from philanthropic organizations,.

KEY ISSUES IMPACTING ON HOSPITAL FINANCING

Demand Side Pressures

1. High population growth rate and ageing population consumes healthcare services a lot more stretching Hospitals and Mental Health facilities.

2. Improved access (both Geographical and Financial) to Health Care Service (NHIS) leads often to frivolous usage / moral hazard when there are no checks or properly functioning referral system interlinking the levels of care.

3. Epidemics of communicable diseases (Cholera, CSM e.t.c) and high non-communicable diseases (Hypertension, Diabetes, Obesity e.t.c) places burden on Hospitals for high attendances and follow up care.

4. Requirement to provide additional services resulting from additional mandates; Training research, teaching hospital, new health cadre e.t.c

SUPPLY SIDE COST PRESSURES

1. **Costs Inflation for Medicines and other Consumables**

The unit costs of services are rising more quickly than overall inflation (Health Care inflation is appx 28%) Inflation for medical laboratory and spare parts for equipments runs at rates above inflation yet tariffs, fees and charges are not regularly reviewed.

2. **Technological Costs**

Improved technology should have driven cost down (more day surgery, short period of stay) but in our instances, new technology drives cost, sometimes up instead.

INEFFICIENCY

- Persistent inefficiency in public sector means that less value is obtained from spending. Indeed perceived weaknesses in controlling excessive spending have led to MOH intervening to calm the storm in some facilities.
- Public procurement and contract management that leads to poor value for money with prices higher than those in private sector leads to excessive cost escalation
- Weakness in supply chain resulting in emergency purchases, expiration of commodities in store or stock outs and burning of stores are problematic.
- Leakages in revenue/weak controls over cash collections still persists even with onsite banks.
- Low productivity - Low payroll management, “ghost names”, absenteeism at work, studying employees’, (overall information on some Hospitals workload suggests no clear trend of improvement over the last 3 years)

SUSTAINABLE HOSPITAL FINANCING

There is the need for a big change.

It is not a matter of introducing a different reimbursement system rather by addressing the systems weakness in the way hospitals are structured, financed and governed.

We must ensure that sub districts, districts, regional level care are interlinked strengthened, monitored and follow through with simple technology: Technology gatekeeper tracking system together with National Ambulance service can locate referral points, empty beds and service availability easily.

Some form of a budget should be dedicated to higher level of care to ensure that the gate keeper system works without running after primary cases for the much needed IGF. Institutional Public Health activities in the Hospital and operational research should also get some funding arrangement

Scientific/Realistic costing of Healthcare services must be instituted annually by GHS, CHAG, Teaching Hospitals & Private Sector so as to present a more reliably costing data to engage the NHIS in setting the next tariff for reimbursement.

Governance and Leadership of our Hospitals must receive key attention. We must select leaders/managers and groom them, arrange courses for them, supervise them to embrace innovative management practices at the various levels of care.

OTHER PERTINENT ISSUE;

Adjudication / Dispute resolution / Mediation

We need a mediating agency to handle issues of delays beyond 60 days by the NHIS to avoid resulting to the traditional courts

Conclusion/Recommendations

1. The relationship between purchasing and service delivery is critical to the achievement of both health financing and overall health sector goals and objectives.
2. A key question is whether the financial incentives in provider payment systems stimulate desired service delivery results.
3. IGF alone cannot run Hospitals, maintain and expand infrastructure

Government must restore the;

- Item 2 & 3 - (now goods &services)
- Item 4 - Investment(Projects)
- SBS(DPF) - Donors must rekindle interest in clinical care and quality of health care services in our Public Hospitals

Recommendations cont"d

4. We must support outreach/mentorship programmes being pursued by Teaching and Regional Hospitals to lower levels of care with a dedicated activity based budget.

5. Community Mental Health services must receive the desired funding.

6. Towards Universal Health Coverage (UHC), Primary Health care can be devoid of out of pocket payment entirely.

Recommendations cont"d

7. However, some secondary and tertiary level will require sustainable out of pocket payments to sustain increasing Hospital costs and must be insulated from NHIS tariff / Reimbursement regime.

8. Hospitals should find other alternative source of revenue such as research, training, local and international affiliations & medical tourism.

THANK YOU