NAZARENE HOSPITAL ADVICE: PARTNERSHIP IN PLANNING FOR FREE/SUBSIDISED HEALTH PLAN

By Dr. Scott Dooley for the NRI 2014 Budget Forum

THANKS

- NRI
- NDOH
- Government partnership
- CHS

UNDEFINED POLICY

- Media announced policy but has not been defined and formal policy released by the NDOH
- Our comments are neither in support nor criticism
- Unique problems of CHS hospitals, especially Nazarene, and encourage continued partnership in defining this policy

PRIVATE/PUBLIC MIX: A UNIQUE CHS STRENGTH

- CHS facilities get public funds and are responsible for reporting and following policies…. However:
- CHS facilities receive significant funds/staffing/volunteers/input from their churches

PRIVATE/PUBLIC MIX: A UNIQUE CHS STRENGTH

- Church resources + fee collection to provide additional service levels beyond their level designation or when system is out of medicines/supplies
- CHS can be a model of efficiency and quality care when given support but autonomous control

PRIVATE/PUBLIC MIX: EXAMPLE

- With salaries NDOH gives 67% of total budget (non-project)
- Nazarene Hospital Operational Budget 2013
- K2 million in actual operating cost (not counting millions in projects)
- NDOH operational budget K367,000 = 18%
- K1.13 million in patient fees = 55%
- Church K300,000= 15%
- Other =12%

PRIVATE/PUBLIC MIX: EXAMPLE

- Church gives much more indirectly –work teams, free labour/housing for doctors and other missionaries provided by mission
  - Value of donated medicines/equipment if purchased is over K5 million per year
- Balance of church and other funds to keep patient fees low and provide highest level of service that we can

REVIEW OF PATIENT FEES

- K700,000 OPD - 52,500 outpatients - a lot of children
- K75,000 Lab/xray fees – spent K177,000 running lab (reagents, path, equip, ancillary staff)
- No pharmacy charge for patients but spent K65,000 for medicines not provided by AMS (shipping donated meds/purchasing)
- K180,000 Inpatient – 5,500 inpatients (avg K32 per admission!)
- K85,000 Surgical fees – 800 major surgeries and lose money on each surgery

2013 BUDGET ADDING FREE/SUBS HEALTH FUNDS

- K277,000 in free/subs health care funds=
  - 13% of 2013 operating costs–
  - or a 25% fee reduction of 2013 fees
- But this is at current patient volume –
- Our volume is already at capacity for infrastructure, bed space, and staffing.
- Too great of a reduction in fees or too great a rise in patient volume without staffing/infrastructure could crash our system

BUDGET COMPARISON

- Mt. Hagen well respected level 6 facility
  - provides about three times our inpatient
  - but less than twice our outpatient numbers
  - has over 3.25 times the staff and
  - over 10 times the operational budget!
- Government hospitals also get:
  - separate maintenance ancillary staff budget
  - primary health budget – done by Provincial Health

- Our budget catered for maintenance, ancillary, and 15-20,000 free primary care visits per year at hospital and outreach
- We are the distribution centre for other facilities
- Nazarene Hospital -allocated for 101 professional positions but employs 120 professionals using pt fees and church funds to cater for volume which exceeds our facility designation

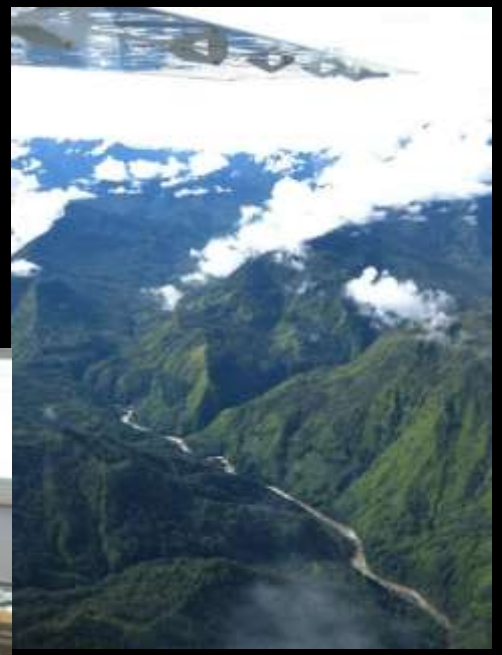
NEED FOR A MORE EQUAL PARTNERSHIP

- CHS does 50% of national health care but isn't always considered equally
- K20 million in free/subsidized health care - CHS got K5 million
- CHS operates majority of the level 1-3 facilities that provide free care – many remote and costly to run
- CHS CHW's, NO's, Doctors,… not equal pay

NHM Rural Health Services

FACILITY LEVEL READINESS FOR FREE/SUBS. HEALTH CARE

- Aid post
- Rural health centre
- CHS rural "hospital"
- CHS accessible larger "hospital"
- Government Provincial and Regional Facilities
- Urban clinic



FACILITY AND SERVICE LEVEL DEFINITIONS

- All CHS hospitals are listed as level 3 health centres! – If Nazarene continues to be listed as level 3, does that mean all our services are free!?
- Say Nazarene is level 4 facility – who gets free deliveries?
  - ASW District? - >200,000 patients
  - However if OB referrals only – where do people near Kudjip deliver?
  - How do we know who is from "local", from ASW, vs longwe?
- Are District Hospital outpatient clinics referral only? Same questions.

FACILITY AND SERVICE LEVEL DEFINITIONS

- How do we run surgical services for ASW with 1 surgeon?
- Becoming the ASW District hospital effectively is being the provincial hospital with none of the support and none of the input into provincial health!
- This illustrates the complex nature that each facility will be affected in different ways and highlights the need for serious long term planning

THE PROBLEM OF BEING GOOD AND BEING ACCESSIBLE

- The NRI's -"lost decade" study showed that the most important factor for selecting where patients get health care is location and functionality
- People go to the most functional facility they can access
- Accessible CHS and government facilities will face highest numbers

THE PROBLEM OF BEING GOOD AND BEING ACCESSIBLE

- Kudjip already every day has patients from SHP, Enga, WHP, Chimbu, and EHP and often from Morobe, Madang, WP, and even Central/South
- Plan to increase access but does increased access increase function?
- Will patients begin to utilize the least functioning CHS and government facilities?

Patient perception, trust, and past performance will drive demand

NEED FOR SYSTEMATIC PREPARATION

- Complex systematic questions to improve access (a good goal):
- All agree PNG needs better access for deliveries, surgeries, etc…
  - Serious planning in terms of infrastructure, staffing, medication, supply, lab, surgical availability, accountability, etc..
  - Water and power in health centres
  - As many Govt. and CHS HC's open and fully functioning

NEED FOR SYSTEMATIC PREPARATION

- Systematic preparation for increased access- example of Minor illnesses/injuries
  - Patient driven- Pain medicine - Gauze/plaster
  - Staff driven- Antibiotics/Malaria medicine/labs
  - All things that have been "nil stock" already this year
  - Increasing pt volume without systematic preparation would end in a national disaster for patients

RECOMMENDATIONS: FACILITY LEVEL

- We would encourage a restructuring of facility levels
- Urban clinics and the most accessible Health Centres near referral hospitals need gate keeping mechanisms
- There needs to be a rural hospital level between 3 and 4 (hospitals with doctors but which aren't big enough to serve the entire District or for which another facility serves that role)

  -CHS has served an important role in training and employeeing doctors for rural areas
  -Masters in Rural and Remote Medicine
  -Adding higher level care/surgery/advanced obstetrics is costly

RECOMMENDATIONS:

- Institute all CHS Technical Assistance Mission Recommendations
  - Register all CHS facilities
  - Equal pay
  - For increased access must then exceed CHS TAM

RECOMMENDATIONS:

- Budget based on actual service provision and outcomes
  - facility budget,staff ceilings, etc.. For both CHS and government
- Continue to include CHS and government facility leaders for long-term planning for implementation
- Improve accountability
- Maximize functionality of entire system

RECOMMENDATIONS

- More gradual implementation of free/subs. health care, especially in urban clinics and hospitals
- Allow special consideration of CHS's unique and effective public/private mix

RECOMMENDATION:

- Gradually increase health funding to meet current deficits first, then decreasing patient fees/increasing access
- Allow each facility to account for what additional free/reduced cost care was provided for the amount given for 2014.
- Then the government can study what was done with K20 million and use as a stepping stone to understand how much more is needed to continue to increase pt access.

QUESTIONS?