GFA Consulting Group

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Component A:
Health Financing

Annex 9
Calculation of Surplus and Proposal for its Allocation under SSK Conditions

- Working paper for discussion -

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1 INTRODUCTION

It is intended that the SSK scheme generates additional financial sources. A particular tool for improving hospital services at UHCs and DH under the SSK scheme will be to have financial incentives available, which shall be used for improvement of the working environment. These financial resources will derive from the financial mechanisms to be implemented under SSK, i.e. remuneration of the defined and agreed benefit package must be sufficient to allow a surplus in the UHCs and the DH.

It is proposed that this surplus is retained at the health providers, which operate under SSK, and that the providers will decide on the according allocation. Optional, a committee shall decide on the allocation of the surplus. As a prerequisite, the UHCs and DH under SSK will have to have partial financial autonomy, which includes power to decide on the retained money and a bank account for each facility.

The surplus shall be used to improve functionality and working environment in UHCs and DH under the SSK scheme: purchase of additional equipment, maintenance of equipment and maintenance of infrastructure. These funds may also be used for topping up salaries.

2 CALCULATION OF SURPLUS

The SSK benefit was defined and 50 Indications were calculated with total costs per UHC at BDT 8,796,896 per UHC per year.

Table 1: Preliminary calculation of the surplus (SSK money to be retained at UHC/DH)

	High case	Middle case	Low case	Deficit (1)	Deficit (2)
	150%	125%	100%	75%	50%
Cost for drugs, diagnostics, and transport for referrals per UHC	8,786,896 BDT	8,786,896 BDT	8,786,896 BDT	8,786,896 BDT	8,786,896 BDT
Revenues from SSK	13,180,343 BDT	10,983,619 BDT	8,786,896 BDT	6,590,172 BDT	4,393,448 BDT
Surplus (yearly)	**4,393,448 BDT**	**2,196,724 BDT**	**0 BDT**	**-2,196,724 BDT**	**-4,393,448 BDT**
Surplus (monthly)	366,121 BDT	183,060 BDT	0 BDT	-183,060 BDT	-366,121 BDT
in EURO (yearly)	43,934 €	21,967 €	0 €	-21,967 €	-43,934 €
in EURO (monthly)	3,661 €	1,831 €	0 €	-1,831 €	-3,661 €

Assumptions:

1. Costing of expenditures for 50 SSK diagnoses is correct and reflects country-wide average with particular regard to expenses and utilization rates. UHC specifics have impact on accurate calculation.
2. Costed prices for 50 SSK diagnoses are minimum prices to be paid by the Scheme Operator.
3. UHC is able to negotiate surplus percentage.
4. Option 2: SSK Cell is defining surplus percentage, e.g. 25 % of costed expenditures.

This calculation shows that based on average costs of SSK services UHCs may make a monthly surplus in case revenues would be higher than prices. Health providers would have to negotiate according prices with the Scheme Operator and at the same time have to economically utilize available resources.

3 PROPOSAL FOR MODEL OF ALLOCATION OF SURPLUS IN UHCS AND DISTRICT HOSPITALS

The facilities (or a local committee) will decide on how to use a surplus. Once per year they shall produce a work plan, which includes all their revenues, not only KfW revenues. Facilities are free to decide, whether they want to buy equipment, repair the facility, invest otherwise, buy medicines for patients, or pay transport for patients or little gifts for women after delivery to make the facility more attractive. Their main interest will be to improve work conditions and work place safety and to make the facility more attractive for clients. The more “paying” patients they have, the more revenues they get. This is the reason, why the facilities even pay the transport for women who want to come for a delivery. It is a major incentive to promote SSK in all aspects.

There is common understanding to avoid that topping ups will "eat up" financial resources for necessary other purposes. Table 2 demonstrates 3 scenarios of different band-widths for selected purposes.

Table 2: Utilization of Surplus by UHC/DH - Model

	Scenario 1	Scenario 2	Scenario 3	Band-width min!	Band-width max!
Maintenance of infrastructure (e.g. repairing toilets, painting walls, sitting arrangement in waiting areas)	10%	15%	25%	10%	25%
Maintenance of equipment (e.g. paper for ECG, films for X-Ray, reagents for lab, fluid for ultrasound)	10%	20%	25%	10%	25%
Additional equipment	10%	15%	25%	10%	25%
Subtotal Maintenance / Equipment	**30%**	**50%**	**75%**	**30%**	**75%**
Doctors‘ salaries	25%	15%	7%	7%	25%
Nurses‘ salaries	25%	15%	6%	6%	25%
Technicians (e.g. x-ray, lab)	10%	8%	4%	4%	10%
Office staff (e.g. accountant, statisticians)	5%	6%	4%	4%	6%
4th grade employees (e.g. cleaner, gardener)	5%	6%	4%	4%	6%
Subtotal Salaries	**70%**	**50%**	**25%**	**25%**	**70%**
Total	**100%**	**100%**	**100%**		

4 CONCLUSION

The risks of generating a surplus for the UHCs and the DH and the implication of not making surplus is in particular need further elaboration. Possible risks are:

- Number of registrations of target population is too low;
- Admission rates are too low;
- UHCs/DH and Scheme Operator cannot agree upon sufficiently high prices.

It has to be defined who will bear the risk of a deficit.

(i) In case the surplus derives from price negotiations between the facilities and the Scheme Operator the according contracts have to define this.

(ii) In case the SSK Cell would set the prices (including a percentage for the surplus for the facilities) the SSK would have to take the risk of a deficit and compensate the facilities accordingly.

After decisions on the final allocation model have been taken by the SSK Cell, the facilities (or the local committee) can decide within this framework on the allocation, based on an annual plan considering the hospitals priorities and needs.